REHABILITATION RECORD

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Disabled People March

See page 24

A Case In Point

The following was written by Peter P. Link, Rehabilitation Supervisor, Van Nuys District Office, California State Department of Rehabilitation. It originally appeared in *Rehab Roundup.*

The *Rehabilitation Record* will print, from time to time, innovative, different, or unusual placements that underline the possible in cases that seem impossible.

Peter McGiffert, a disabled veteran of the Vietnam conflict, came to the Van Nuys District Office for help in July 1968. He asked Howard E. Mackey, rehabilitation counselor, for vocational guidance and help in getting a job. In view of the severity of his client's disability, Mackey contacted Dr. M. Crawshaw, Veterans Administration counselor, and a rehabilitation program was set up utilizing the resources of both agencies.

As a vocational objective was difficult to identify because of McGiffert's severe disability and lack of previous work history, he was sponsored for a work evaluation program at Build Industries in North Hollywood. Although he was capable of handling a college program, he did not want academic training. He was, in fact, very insistent that his only real interest was to become an aviation ground instructor.

He was placed in a group counseling program to help him better understand his abilities and limitations. The workshop evaluation showed that he was not competitively employable in jobs requiring speed and physical dexterity and coordination.

Since McGiffert continued insistently with his desire to become an aviation ground instructor, Mackey contacted two flight instructor schools and found that placement possibilities were generally good and that his client might be able to function as an aviation ground instructor. The VA agreed to pay the bill for the training. The Department of Rehabilitation supplied related services as needed.

McGiffert enrolled for training at Pacific Airmotive Corporation in February 1970 and completed the course with flying colors. In September 1970 McGiffert accepted a position at the San Carlos Airport on the San Francisco peninsula as an aviation ground instructor. To date he's doing great.

His disability? He sustained a head injury in Vietnam, resulting in a restriction of his field of vision to less than 10 degrees. McGiffert is legally blind.

HOMECRAFT

Source of Homebound Employment

Adrian Towne

"Many of the homebound have individual talents and skills which can be developed further . . . The opportunity for the unfolding of such latent abilities is the inherent right of every citizen."

Today, few would question the appropriateness of these words as a creed in the rehabilitation of the homebound.

But back in 1934 there was plenty of question. Then it was a revolutionary creed, spoken by one of the great revolutionaries of vocational rehabilitation: Bill Faulkes, chief of Wisconsin Division of Vocational Rehabilitation (DVR) for nearly a third of a century and the man who more than any other was responsible for extending rehabilitation service to the homebound.

His words became substance in 1940, and during the next 31 years, 15,000 severely disabled persons in Wisconsin were served by DVR's Homecraft service, the oldest continuous statewide effort of this type. Even though Wisconsin is a leader in rehabilitating the homebound, we still don't get far below the surface. The best educated guesses on the extent of the homebound problem places the incidence at 1 in 1,000 or some 2 million nationally and about 4,400 in our State. Currently we are serving 750 clients, and service has been requested for another 600, the delay caused by budget induced program limitations.

It is hard to realize that I am talking about a program established 31 years ago, and, even at that, we are far from meeting the need. But some States have virtually no rehabilitation program for the homebound or have started one only in recent years. As a result, best estimates are that nationally fewer than 5 percent of the homebound receive rehabilitation. This is particularly tragic, since it has been conclusively demonstrated that the homebound have talents that can be cultivated.

Homecraft, of course, is not the only type of homebound rehabilitation program, but it is the oldest and most widespread. It apparently lends itself particularly well to the Midwest, evidenced in programs in Wisconsin, Minnesota, Iowa, Missouri, and Michigan. Homecraft seems to work out well in a nonmetropolitan setting. In Wisconsin, for instance, 26 percent of our clients come from rural areas, 28 percent from communities under 10,000, and another 28 percent from communities under 50,000. That leaves only 18 percent from the major population centers.

Mr. Towne is Administrator, Wisconsin Division of Vocational Rehabilitation. *This article is based on his keynote address to the Midwestern Regional Conference on the Rehabilitation of the Homebound. The Conference was held in St. Louis, Mo., in January 1972.*

In order to cover this much ground, we need an instructional staff of 24 skilled arts and crafts teachers working out of DVR field offices in all parts of the State. These instructors, all with at least a bachelor's degree in art education and certified by the Department of Public Instruction, must motivate the client to learn a craft activity suitable to his interest, disability, and home situation. After a craft has been selected jointly by client and teacher, DVR provides instructional materials. Essential equipment may be provided with a residual title (the equipment reverting to the State if no longer used by the client).

Principal products outlet has been the Easter Seal Society with stores in Milwaukee, Madison, and Appleton. United Cerebral Palsy operates a store in Madison, and various women's organizations, such as the University League in Madison, provide active and profitable outlets. These efforts resulted in total sales last year in excess of $250,000, all of which was returned to the clients.

A much newer approach is through industrial homework which has been described as a one-unit sheltered workshop. The client constitutes an industrial plant in microcosm. The client's contact with industry is through subcontracts usually made available to him through a sheltered workshop.

Advocates of this type of program point out that, unlike the crafts programs, they have no merchandising problems since the products are on order from cooperating industry. Advocates also claim that production is not subject to the peaks and valleys of demand found in the crafts. Some proponents of industrial homework like the idea that the worker is anonymous, that his work is not identified as the product of a disabled person.

Unquestionably, there will be many clients better suited to industrial programs. The person who has no creative needs and who enjoys repetitive manual tasks will find an industrial set-up preferable. But since this type of work usually calls for good bimanual dexterity, many homebound clients will be excluded. Industrial projects are apt to have greater space requirements, a ruling out factor for some clients.

Rehabilitation of the homebound has to be carried out within the narrow limits established by rheumatoid arthritis, heart disease, amputations, cerebral palsy, uncontrolled epilepsy, emphysema, and just about every severe disability that rules out participation in the competitive job economy. A rural paraplegic, no longer able to do her job at the farm co-op, finds new success in making dolls that are in demand at the Homecraft store. An arthritic has to retire as a telephone lineman, but in a home workshop he develops skill as a woodworker. These and thousands more do not have to call it quits when disability removes them from the labor market. Homecraft often can help bring to the surface latent skills which keep them productive, emotionally healthy, and earning.

Incorporating the same basic concepts as do the regular vocational rehabilitation services, a homecraft program considers both the client's emotional and economic needs. But with the homebound perhaps even more than in the regular program, recognizing the subjective values and appreciating the psychological importance of work is vital. Meaningful activity sometimes becomes the difference between home or institutionalization. Not infrequently we find an individual whose isolation has taken a great toll. His separation from society may be vast, sometimes even to the extent that he scarcely identifies with the outside world. This almost schizophrenic situation is a manifestation of monotony and loneliness. One of the goals of homebound programs is to reestablish client real world identification.

Freud put it rather well in his *Civilization and Its Discontents*:

> Work has a greater effect than any other technique of living in the direction of binding the individual closely to reality. In his work, at least, he is securely attached to a part of reality, the human community.

Obviously, Freud did not have in mind the rehabilitation of the homebound, but his words apply.

There are advocates of replacing rehabilitation programs for the severely disabled with cash payments. They contend that rehabilitation is more costly than productive, that everyone would be ahead in a strictly cash exchange between government and the disabled with no vocational rehabilitation agency as a middleman. Also some disabled individuals feel that the emphasis on a work goal is unfair. One was quoted in a recent study:

> I am convinced that we should not elevate the idea of work in our minds to the point where it dominates values that ought to transcend it. It is

Homecrafter displays highly saleable Raggedy Ann cloth dolls.

important not to do this, if only because it causes the most acute suffering in those who can't help being parasites on the economic body. . . .

But we are not dealing here with the idea of an obligation to work, such as Poor Richard's dictum that "work is no disgrace, the disgrace is not working." Rather, we see work as a tonic, vital to emotional well-being. In this context work is usually more therapeutic than monetarily rewarding, not so much a matter of sustaining the body as of protecting the mind against the ravages of isolation. Participation in homecraft can provide a long-range purpose to life as contrasted to the psychologically devastating sterility of a day-to-day existence in a vacuum. Not infrequently our homecraft instructors hear such comments as "You have kept me from losing my mind" or "Everything takes on a new look since I've been on homecraft."

The Bible tells us that man does not live by bread alone. But that was before the era of cost-benefit analysis. Unfortunately, the nonmaterial factors do not add up well in the benefits of homecraft, although their cost is evident in the breakdown.

A regular DVR client who is successfully rehabilitated to competitive employment usually shows the type of cost-benefits ratio that enables DVR to boast that he soon pays back in taxes what it cost to rehabilitate him. This is not so certain at the homebound level. Many homecrafters may show a negative cost-benefits ratio because the most important benefits remain untabulated for analysis. Perhaps training and equipment costs of $1,200 must balance against yearly earnings of only half that. If money were the only benefit involved, the cost-benefits ratio would scarcely show a successful rehabilitation. But some things do not carry a price tag and cannot be tabulated.

The client, previously on the verge of an emotional crack-up, gets back in step thanks to her success in homecraft. How can this be shown as a dollars and cents benefit? I suppose one could estimate the cost of psychiatric care and extended institutionalization which were avoided, but the results would not be acceptable to most analysts of costs and benefits. We know the subjective benefits of homecraft are high but until those benefits can be quantified and given a per-hour value, they will remain nonexistent for the skeptics. Man does not live by bread alone. Homecrafters like bread, but they are the first to acknowledge that food for the spirit is even more important in a body wracked by pain or paralysis.

From the standpoint of personal satisfaction, a homecraft program does stand out. It serves to meet the demand for creativity absent in so many lives, handicapped or not. The joy of creating is usually not found in the typical industrial homebound programs. There, the client may be limited to a single job task, as in industry, perhaps never seeing the completed product. On the other hand, craft work enables the client to progress from raw material to finished product.

Few people today are lucky enough to see a job through to its completion, a fact that some authorities see as a cause of an almost pathologic emptiness in many lives. The era of the craftsman is past, replaced by an assembly line turning out mass products which excell in little but their psychological obsolescence. The cry most frequently heard today concerns the lost pride of workmanship in the finished product. So a vital part is missing. Who cares? It's guaranteed. But a remnant of the former era remains, the spirit of the craftsman in the homecrafter who may still spend weeks turning out a beautiful desk. It is one of a kind, from solid wood, something which can be displayed proudly for decades!

Admittedly, not all homecraft creations are going to be collectors items. Some are simple toys or household items, not the height of creativity but nevertheless saleable. Most important, they all have this overriding characteristic: each product is one client's personal answer to the problem of disability.

In tending to minimize the monetary in favor of the subjective rewards, I must not overlook the fact that substantial earnings can be made by the homebound. There are documented instances of earnings at the $5 to $8 per hour level for homebound workers engaged in computer programing and related business areas as a part of demonstration projects.

But I must, in all candor, stress that such earnings cannot be considered a realistic goal for most homebound programs at this time.

Wisconsin DVR can point to individual homebound clients highly successful in providing accounting, secretarial, and other nonhomecraft services from their home. But when we think of organized programs for the severely disabled, clients usually will be less fortunate.

It would be easy but quite unfair to emphasize the rich rewards possible for the severely disabled. In Wisconsin, all quadriplegics could be offered the hope that they can do as well as an outstanding University of Wisconsin professor. Although a quad since high school, he secured his Ph. D. and today is an associate professor, known as one of the better teachers on the Madison campus and active as a real estate developer and consultant who travels extensively—all this without any help from his own arms and legs. But he is no more a typical quadriplegic than Beethoven was a typical composer.

In considering the values of homecraft programs, we cannot forget their public relations importance for the participating agencies and the homebound themselves. Individual homecrafters make news throughout the State and become identified as a part of a unique rehabilitation program. The shops, run by the Easter Seal and Cerebral Palsy organizations, have made homecraft a household name in Wisconsin, a place to secure quality art and craft items ideal as gifts.

Special events are built around the homecrafter and his products, such as the fairs at Christmas and Easter sponsored by local groups. Take for instance the University League in Madison. This organization each year promotes the sale of homecraft products at a yuletide fair. They handle the promotion and get superb press coverage. Sales boom, and many more persons each year discover homecraft shops as the answer to gift problems. At the same time, customers understand just a little bit more about the disabled, a fact that in itself can be beneficial in establishing greater acceptance.

In a locket, an etching, a rug, a wallet, and countless other creations, the buyer can see skill coupled with courage. The hands that produced what may well be an heirloom piece did it in spite of arthritic misery, a fact not lost on the purchaser who asks about the craftsman. The program reaches many more thousands than those immediately involved. The clients' families and friends, homecraft customers, other social agencies, and the like find in the

homecraft program man's humanity to man at its best.

I believe that homecraft programs will continue to dominate the homebound rehabilitation field within the foreseeable future, but this is not to say many important innovations will not influence homebound rehabilitation. Advancements in all phases of electronics hold out great hopes, some of which have already been demonstrated at project levels.

A research effort at George Washington University (*Rehabilitation Record,* November–December 1970) seeks to fit the severely disabled into the so-called information revolution, preparing them for jobs in computer-related work in banking, insurance, and communication. They have found many homebound well suited to such research vocational goals as microfilmer, microfilm editor, microthin jacket filler, computer programer, keypunch operator, and more. The project report cited a quadriplegic who with automated tools could hourly fill 105 transparent chambers with strips of 16 mm roll film. After paying for her equipment rental, she was still netting almost $5 an hour. It is conceivable that the combination of electronic equipment plus automated tools will open a vast market for certain of the homebound, but for the time being such hopes should be kept within realistic limits. The important thing now is that their possibility has been demonstrated. Unfortunately, for most of the homebound, this may remain science fiction for a number of years.

There are many problems to be solved before we reach the electronic utopia. We've got to make every effort to stimulate Federal interest in the homebound during the 1970's. A start on projects has been made and the severely disabled are on the Rehabilitation Services Administration priority list. Of course, in view of the experience of the 1960's, just about anything will be an improvement. From 1955 through 1970, only 19 (or 1.2 percent) of 1,556 projects were devoted to the homebound. Of the more than $69 million spent for research and demonstration efforts, only $1.8 million (or 2.6 percent) went into the area of the homebound.

Thirty-five years ago President Roosevelt told the Nation that "the test of our progress is not whether we add more to the abundance of those who have much; it is whether we provide enough for those who have too little." In applying that test to the severely disabled, the lack of progress is evident. Rehabilitation of the homebound has no place to go but up.

Outstanding Federal Employee

James B. McGinley, manager of the Social Security Administration's district office in Whittier, California, receives an outstanding handicapped federal employee award certificate from Patricia Nixon Cox. McGinley was one of ten finalists honored. The top award was presented to Shirley K. Price, a NASA administrative aide. HEW Assistant Secretary Patricia Reilly Hitt shows her elation at McGinley's recognition.

Research And Demonstration:

John H. Noble, Jr., Ph. D.

BETWEEN 1953 and 1966, while the gross national product of the U.S. doubled, total funds for basic research increased sixfold. The Federal Government increased its support of basic research from one-half to two-thirds of the national total during the same period. Federal support of research in universities more than doubled from 1959 to 1964. In 1966, $18.9 billion was spent for applied research and development compared with $3.2 billion spent for basic research—almost a 6 to 1 ratio.[1] These trends reflect expansion of a commitment to basic scientific research, promoted by Vannevar Bush in 1945 as indispensable for the nation's welfare in war and peace, to include applied research of every conceivable type.[2] They also give indication of how much the stature and authority of the scientific community has grown.

What has come of these vast commitments of resources? We look around us and see everywhere the benefits of a technological society: conveniences that were beyond our wildest dreams just 25 years ago at the end of World War II. Engineering feats have not only bridged physical distances on earth but also reach out to the planets. Telecommunications have collapsed time and space, making possible contemporaneous experience of events anywhere on earth and occasionally on the moon. Biomedical discoveries have conquered poliomyelitis, offered a shield against influenza, provided a cure for tuberculosis, allowed more predictable birth control and family planning, and supported organ transplants.

The technological society and its artifacts have also created problems which did not exist before in number and/or scale. Some time ago, the *Washington Post* carried a story about the action of the Food and Drug Administration endorsing the findings of a study of oral antidiabetes drugs which indicated that "in long term use, such drugs lost their efficacy while sharply increasing the probability of premature death from heart attacks, strokes and other vascular complications of diabetes." [3]

Behind this release lies a rather sordid tale of maneuvering by special interest groups to discredit and suppress the study's findings. The *Washington Post* reported "massive resistance from important segments of the medical profession that relied on the pills to hold down sugar levels in the blood. . . . Critics made sharp and sometimes even personal attacks on the authors (of the study) at medical meetings. Canada's Food and Drug Directorate and Britain's Committee on the Safety of Drugs initially downgraded the value of the study. And manufacturers fanned the controversy from the start by sending out reassuring 'Dear Doctor' letters." [4]

Not long before that, the birth control pill had the limelight. In fact, hardly a day passes without television, newspaper, or radio coverage of some outrage perpetrated against the public and/or the environment by technological innovations. Under the circumstances, it is not surprising that the belief in the inevitability of progress through the advancement of knowledge has come under attack.

Chairman Emilio Q. Daddario (D–Conn.) of the House Science Subcommittee, summing up several weeks of hearings, "warned that the country's 'scientific estate' is decaying by virtue of a 25 percent decline in Federal support in 3 years." At the

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The Crisis of Legitimacy

same time, he declared that "the country is suffering from deep lack of understanding of social and environmental problems; from painful 'educational instability aggravated by shaky federal funding'; and from an increasingly secondary position in world trade in advanced products." [5]

What is the significance of these happenings? How should we react in looking forward to the next few years in planning research and training center activities? In broadest context, Reinhard Bendix, in his 1970 presidential address to the American Sociological Association, interpreted the upheaval currently affecting the scientific community as symptomatic of a shift from the belief in reason which has generally characterized Western civilization to its opposite pole, the tradition of romantic protest (Luddism) which has also found expression throughout history. As summarized by Bendix:

> These views (the praise of art linked with a promethean image of the poet as godlike) from Shaftesbury and Goethe to Carlyle and Nietzsche meant, as Novalis put it, that "poets know nature better than scientists." Such sentiments have a close kinship to attacks on the abstractions characteristic of all academic work. For Nietzsche all scientists were plebian specialists and the worst enemies of art and artists. Kierkegaard made the primacy of living over reflecting his central theme . . . . In calling for more life and less thought, for more poetic imagination and less abstract reason, the romantics attacked considerations of utility and the idea of material progress.[6]

It is in these terms that Bendix understands the sharp rise in student protest rather than in terms of generational conflict. It is an ethic of social despair and distrust of reason which motivates students, some faculty members, and not a few writers:

> Faced with ultimate horrors and proximate evils, protest draws once more on the arsenal of cultural pessimism with its total rejection of competition, efficiency, the division of labor, considerations of utility, and the whole world of technology . . . . The old promise of the enlightenment has become tarnished—the promise that knowledge is power for the benefit and use of life.[7]

In this crisis of legitimacy, Bendix advocates that sociologists adhere to a belief in the possibilities of human reason, ever aware of the tensions and debates between the scientific and humanistic impulse. On the other hand, he advises that methodological concerns not be permitted to encroach upon matters of substantive importance—a position with which I personally would take issue.

As research and training centers attempt to plot a course over the next few years, they face a similar crisis of legitimacy. And all researchers housed therein, regardless of professional and/or disciplinary affiliation, have the considerable challenge of demonstrating the efficacy of reason in providing solutions to today's problems, of which not a few are attributable to yesterday's application of reason.

As a criterion for deciding what is substantively important, I offer in a circular fashion: "today's problems." However, I also submit additional criteria for judging relevance of research and training endeavors; viz: (1) conformity to those objectives periodically enunciated by the Department of Health, Education, and Welfare that involve the greatest number of agencies and programs and (2) directions implied by truly comprehensive as-

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- ☐ The Deaf
- ☐ Catastrophic Disabilities
- ☐ Rehabilitating Disabled Public Assistance Clients
- ☐ Hemophilia Center At Work
- ☐ The Maxillofacial Centers
- ☐ On Media And Rehabilitation
- ☐ Mental Illness
- ☐ Mental Retardation
- ☐ Michigan's Approach to the Ghetto Client
- ☐ Multiple Sclerosis
- ☐ The Rehab Aide
- ☐ Rehab In the Schools
- ☐ Transportation for Disabled

sessments of the "state of art" in any given program area.

Furthermore, in a period of austerity wherein competition for scarce resources is likely to be unusually fierce, I would recommend a marginal approach to new commitments and/or redirection of effort. Given departmental, regional, and State priorities, hopefully synchronized to a greater degree than has been the case before, where may resources be directed to obtain at margin the highest payoff in knowledge immediately applicable to program modification and development? The process of searching for this sort of information at the SRS Regional Office and State agency levels, and involvement with agencies and programs at these levels, I think, will pay off in continued support for the research and training centers. In this regard, I am suggesting that the relationship between research and training centers and agencies within their respective regions be symbiotic.

On the other hand, I am not suggesting that these centers allow objectivity and perspective to be lost by virtue of heightened involvement with service agencies and programs. Hopefully, the spirit of mutuality, cooperation, and shared responsibility for better programs, more immediately applicable knowledge, and directions for additional research will prevail. If it does prevail, I am confident that the research and training centers will survive and make progress during the present crisis of legitimacy.

The model for the kind of collaborative effort that I believe is needed lies in George W. Fairweather's book, *Methods for Experimental Social Innovation*. Changing what must be changed to fit the various types of research and training conducted in the research and training centers, Fairweather's discussion of the role of the experimenter in attempting to establish and evaluate the impact of social subsystems as alternative solutions to given social problems has relevance. It recognizes that the outcome of any such subsystem is dependent upon the individuals who participate in it and the social context in which the subsystem is operative.

As such, it fixes responsibility upon all participants in the subsystem for outcomes. To the extent that participants in the subsystem can produce desired outcomes within the constraints obtaining within the operative social context, a solution has been found and the "success" of the collaborative effort defined. Because the model emphasizes development of consensus about what the social change outcome criteria will be, it is particularly powerful in welding program and research objectives together in a manner which sets the stage for collaborative effort.[8] It is my hypothesis that those research and training centers embarking upon development of subsystems in their respective regions that draw together participants necessary to the solution of problems having priority and fiscal support will fare best in the next few years.

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Community Counseling Services For Deaf People

William N. Craig, Ph. D., Edgar Shroyer, and Julianne Seifried

Critical to the independent functioning of deaf people in modern society is the availability of community resources to provide services at certain opportune times. Most hearing adults are aware of resources in their home communities and many people avail themselves of these services rather automatically. But this promise of assistance is at best illusive for the deaf person who is faced with uncertainties and who recognizes the difficulty of communicating with hearing adults who work in these service facilities. Early in 1965, this essential need for community service, as expressed by deaf people in the Pittsburgh area, evolved into a proposal for community action.

A rather unique experiment for providing counseling services was attempted in proposing a combination of cooperative efforts involving the Pittsburgh Hearing and Speech Society, the Western Pennsylvania School for the Deaf, and State and federal offices of vocational rehabilitation. The central objective was to develop a center for counseling with deaf adults and then to organize existing service agencies sufficiently to apply their particular skills in behalf of deaf people. Thus in 1966, with the help of an SRS research grant, a counseling and community service center was established in Pittsburgh.

Services include: adult education, counseling and guidance, legal assistance and referral, personal assistance in activities of daily living, consultation, employment assistance, evaluation, and mental health services. The following examples show the application of these services.

A 22-year-old man sustained a severe hearing loss which contributed to a critical emotional problem. To complicate the situation further, vision in one eye was affected. Although he hoped for an education and a responsible job, he was unable to determine a way to achieve these goals. Center resources were used to build self-confidence, to develop a new set of communication skills, and to place him into a college program. The key factor here was that an individual suddenly faced with personal catastrophe was able, with assistance, to work toward a new lifetime opportunity.

In another case, a deaf immigrant to the U.S. was having difficulty adjusting to his new surroundings, and he was having trouble holding his job.

Dr. Craig serves as project director of the SRS-supported project described here. He is also superintendent of the Western Pennsylvania School for the Deaf. Mr. Shroyer and Miss Seifried serve as director and associate director respectively of the Counseling Center.

To compound the problem, he was also a victim of a street assailant, and, subsequently, he labored over the nuances of explanation to the police. The counseling services provided ranged from the short term patching of the employment and legal problems to the longer range objectives of teaching English skills.

Development of the Counseling Center

Starting with few guidelines and no previous experience, we developed the general concept of a cooperative counseling and community center into an operating facility. Certain related studies did serve as markers for the need for a center and also as guides to the major problem areas. Of particular note were studies of counseling services in Boston,[1] St. Louis,[2] and Hot Springs.[3]

Unlike some more specialized counseling facilities, the Pittsburgh effort was first directed toward assisting deaf individuals in making better community adjustments. More recently it has expanded to include direct services in mental health and related areas. Primarily the effort is one of counseling and referral. Perhaps one of the significant features is the close working arrangement between the Center and the Hearing and Speech Society—a logical arrangement but one that previously had been only partially explored.

Although the Counseling Center is funded as a research program through the Pittsburgh Hearing and Speech Society, it is not housed with the Society, but, rather, it serves the deaf community in an area in which deaf people are most familiar. The setting selected is across the street from the Western Pennsylvania School for the Deaf and next door to a church for the deaf. This locale has become a catchment area for services sought by the deaf in Allegheny County. Because of the school's closeness, Center staff can call upon additional professionals when such services as consulting, interpreting, and tutoring are needed.

The basic Center program is designed to make available those community services which would ordinarily be inaccessible for deaf persons and to provide direct services where outside sources are unavailable. Initially, much direct counseling is necessary, as it is often quite difficult to locate a resource facility or agencies prepared to accept a deaf client. The situation changes as other agencies become aware, through education, of deaf needs. Once existing community services have been so educated, the role of the Counseling Center expands to include many more indirect as well as direct services.

Services Offered

Services provided by our Center are as follows:

Establishing contact with the deaf community. This requires knowledge of the language of signs, knowledge of the social and interpersonal desires of deaf people, and an ability to demonstrate that unique services are available to them. The latter two objectives are met mainly through meetings with the advisory board which consists of 12 deaf persons.

Staff members frequently visit local associations of the deaf and talk with the officers and members of these associations. Basic information, usually not available to deaf persons through normal channels, is made available through articles written by the Center's staff and printed in the local deaf association's monthly bulletin. The information is general and regards eligibility for medical assistance and food stamps, the employment picture in certain areas, and available adult education classes.

Selective attention to the resources and capabilities of agencies which might provide for physical restoration. These agencies might include medical, audiological, speech, language, psychological, and vocational referrals. These services can be covered by the Bureau of Vocational Rehabilitation authorizations. Our unique contribution lies in selecting appropriate services, preparing the client and the agency in terms of the needs of the individual, and coordinating action to assure the successful facility utilization. Agency preparation is accomplished through consultation with and inservice training of selected agency staff.

Specialized vocational and social adjustment training. In addition to inhibiting day-to-day communication with hearing people, deafness significantly interferes with the acquisition of knowledge about the world of work, activities of daily living, and the nuances of appropriate social interaction. The Center's personal adjustment training program meets individual needs in all of these areas.

Many clients do not have adequate communication skills so, as a first step, they are taught this basic skill. Individual vocational and social needs are brought into perspective at this point. The client may be given experiences such as riding a bus, shopping, attending church, visiting a club, seeing people in work settings, and visiting agencies and job set-

Speech indicator (at left) allows deaf people to pose questions requiring either yes or no answers. The person receiving the call responds either "yes" or "no-no", moving indicator needle once or twice, respectively. (At right) Deaf driver education session underway.

tings of personal interest. He may be given direction on how to fill out job applications, how to budget, and how to perform certain employment routines.

The ultimate goal of this training is to prepare the client to function appropriately, both in the vocational and social areas.

Psychological services and clinical testing. Because the psychologist's major tool is verbal communication, careful attention must be paid to evaluations of people whose hearing impairment has critically affected this verbal ability. Alternate means of communication must be established in many instances, and verbally related concepts frequently must be developed from nonverbal materials.

Our staff includes a psychologist who is experienced in assessing deaf persons and in organizing a constructive plan for each. He may cooperate with a psychiatrist to provide a treatment service. He has been effective in working with persons who become deaf due to trauma or illness late in life.

Psychiatric services. The Center is licensed in Pennsylvania as a psychiatric outpatient clinic and provides the only psychiatric service for deaf persons in the Pittsburgh area.

It is relatively impossible for a psychiatrist without communicative skills or background knowledge of deafness to effectively work with deaf people. In cases where the psychiatrist uses an interpreter, the interpreter should be chosen with a view toward the sensitivity and confidentiality of the situation. To assure patient and psychiatrist communicating, the interpreter should be in the background as much as possible.

A recent contract between the Center and Dixmont State Hospital insures the continuity of psychiatric service. Dixmont State Hospital will establish a unit for deaf persons, and the population will come from all the State hospitals in western Pennsylvania. Both agencies will work together for optimum services on an in and outpatient basis.

Personal indepth counseling. Individual or group counseling, according to need, is provided. Our counselors have expert skills in manual communication and a working knowledge of the recurring problems and needs of deaf people.

The types of counseling sought range from consumer questions to such sensitive areas as marital problems and severe personality disorders. As an example, we have counseled a young couple who have adopted a hearing child. Not only was the couple counseled prior to the adoption, but counseling has continued for the past 3 years, in the post adoption period.

Adult Education—selected subject areas. By being familiar with the educational background of deaf individuals, the Center, through its advisory board, is able to identify those areas where adult education would be most helpful and to provide experienced, qualified teachers of the deaf to conduct the classes. Examples already given show that deaf people do profit from these classes. The Center has made application to the Commonwealth of Pennsylvania for certification to continue these classes under adult basic education funding. Some of the popular courses include: driver education, typing, basic English, arithmetic, and preparation for taking

the Post Office civil service examination for clerk-carrier.

Development of community resources. By serving as a central service resource for deaf people, the Counseling Center sees a large number of deaf persons each year. It is able to gather information about the specific needs of groups of deaf people. From this data, it is then possible to go out into the community and locate agencies that have not, to that point, served deaf clients; to provide an orientation to the agency; to identify key staff additions for them; and, thus, to provide a service for deaf clients where none had previously existed. No other agency in this area has the capability of providing this service.

Some of the agencies which we have assisted in working with deaf persons are: The Vocational Rehabilitation Center of Allegheny County, Beaver County Rehabilitation Center, Dixmont State Hospital, Pennsylvania Rehabilitation Center, Woodville State Hospital, and Goodwill Industries. With the cooperation of the Pennsylvania Society for the Advancement of the Deaf, we were also instrumental in establishing the first chapter of the Registry of Interpreters for the Deaf in Pennsylvania.

Expansion of educational service. Underemployment and underdeveloped potential among deaf people is offset by the provision of tutors, note-takers, and interpreters. These have been used in the following settings: University of Pittsburgh, Computer Data Institute, Allegheny County Community College, Penn Technical Institute, Point Park College, and several others.

Development of professional specialists with the deaf. As a practicum arm of the University of Pittsburgh Graduate School, we aid in the training of professional specialists with deaf clients. Since a critical local and national need exists, the Center provides an extremely important inservice resource for this training. In fact, we are one of the few in the United States providing this base for educational experiences. In addition we assist in teaching manual communication to the University of Pittsburgh's graduate students in deafness.

Housing service. Housing for clients who are participating in the personal adjustment training program at the Center is available in the Pittsburgh area. Placement has been possible in several locations, including in a private home with a deaf family, at Transitional Living Services, or at the YMCA.

Interpreting. The interpreting service provides the vital link between the deaf client and the quality and quantity of service he is to receive. It may be rendered in vocational, legal, religious, medical, educational, or information-giving settings. Our staff often has been called upon to provide interpreters for other agencies and individuals. The service is available on a moment's notice since the staff is on-call 24 hours a day.

The need for this service is paramount and is reflected in the Center's endeavors to establish a local chapter of the Registry of Interpreters for the Deaf and to get the Commonwealth of Pennsylvania to pass legislation making it mandatory that all deaf persons in any legal setting have an interpreter available. This legislation is still pending.

Personal assistance. The bulk of our service is the provision of personal assistance which can include such client assistance as helping him understand his insurance policy; explaining Social Security benefits; showing him how to secure a bank loan or how to purchase a house or how to fill out an application. We may also assist him in learning about Medicare, Medicaid, food stamps, or how to apply for medical assistance or legal aid. The list goes on, and it involves many of the things taken for granted by hearing persons.

Evaluation of Program Effectiveness

Assessment of the effectiveness is complicated not only by trying to reduce services to numbers but also by the extent the person needs, uses, and appreciates these services. As shown in the examples offered earlier, these services may mean the difference between a person being able to cope adequately with his adult responsibilities and a person becoming dependent on community generosity.

Center activities also can be seen through its case flow over a 6-month period. During the most recent period, 320 deaf adults were seen by staff. Three hundred and three cases were closed while the remainder continued on longer term basis. Over half of the total was seen for assistance with personal and economic problems or for counseling. Consultation with employers and service facilities accounted for 87 professional contacts. Other services, including interpreting, tutoring, adult education, referrals and further evaluations accounted for the remainder of case services.

The scope of these services points up not only in-house activities but illustrates the extent of community involvement. As a demonstration program, its effectiveness is best reflected in the continued active support of deaf people who avail themselves

of its services. Financial support also comes from a wide base, including individual, fees for services from the BVR, and from agencies such as Community Chest.

Its uniqueness lies both in its community outlook and its expansion of services to meet changing needs. A service of this type readily can be established in other cities if a few vital ingredients are included. These consist of the initial interest of a sound social agency, the confidence and support of the local deaf community leadership, an initial financial commitment to underwrite the costs of getting started, and the selection of key staff members who can gain the confidence of potential clients. This investment of effort logically follows a careful survey of the extent and nature of the needs of the community for services and an assessment of the proposed program to meet these needs. These factors should lead to the development of a vital service which can function on its own merits and at costs within its own income potential.

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Notes on Plain English

Mark Twain once said: "The difference between the right word and the almost right word is the difference between lightning and the lightning bug." Of course, that statement does not account for the use of language to purposely perplex the reader and prevent him from entering the sacrosanct domain of the profession. S. I. Hayakawa gives a good example of this fuzzing when he challenges physicians "to explain to me the difference between 'new-born baby' and 'neonate.' " We will not challenge anyone for a statement of difference in this group of words which we heard recently—"critical path approach." We won't challenge the expression of difference because we just don't know what to contrast it with.

But it seems that all the professional disciplines are guilty in the explosion of terms, to the point that William Gilman, in his book *The Language of Science,* expresses hope that "the technicians will find courage to transform 'ratio of load to deflection' into 'stiffness' and 'cause loss of stability in directions transverse to the load' into 'causes buckling.' " A bit less hopeful are the words of Robert A. Walker who charges that "The journals are already producing articles which, in keeping with the true nature of professionalism, are barely readable."

It's a comfort in some ways, a disappointment in others, to know that involved styles of writing plagued the people who were helping run this country in the days of Thomas Jefferson, just as these murky styles plague us all now. Mr. Jefferson recalls in his autobiography that, in 1776, when he and two other distinguished residents began the complete overhauling of the statutes of Virginia, they examined the Virginia Acts of Assembly, "which, from their verbosity, their endless tautologies, their involutions of case within case, and parenthesis within parenthesis, and their multiplied efforts at certainty, by 'saids' and 'aforesaids,' by 'ors' and by 'ands' to make them more plain, are really rendered more perplexed and incomprehensible, not only to common readers, but to the lawyers themselves."

We don't know if the legal morass has been altered—we suspect not—but we do know that verbosity is gaining ground in the culinary field. A *Washington Daily News* editorial contrasted the picnic fare given to King George VI when he visited Mr. Roosevelt and that consumed by Prince Charles and Princess Anne on a visit to Washington. The latter, according to the menu, ate "grilled chopped sirloin patties and all-beef frankfurters with bun" while the former ate hot dogs.

We can't think of a better way of ending this article than by quoting the following stanza from a poem entitled "Words, Words, Words!" by Ronny Gilmore:

When one word'll do it
Just let it ride!
You don't need another
Right by its side.

Keeping Them Down on the Farm

L. B. Kerr

Jackie Wiggins and Beagle (Snoopy?) inspect goldfish ponds.

The title, agriculture specialist, fits Ben E. Rice like a shuck covers an ear of corn, snugly, comfortably. It should, because Rice has been engaged in farmwork, or a related field, for almost 40 years.

With a background of farm living, which dates from birth, and a knowledge of raising livestock, poultry and rabbits, cultivating pastureland and other crops, and a head for business, acquired over the years, Rice is a natural to fill the position of agriculture specialist for the Arkansas Rehabilitation Service.

He joined the agency in 1960 and from that date more than 200 disabled persons have profited from his advice. The disabled were persons who knew little else than farming or stock raising.

Rice is an innovator, not afraid to try something new. For instance, Jackie Wiggins, who had lost his left hand in a sawmill accident, told Leon Underwood, his rehabilitation counselor, that he would like to raise goldfish. The counselor called in Ben Rice for his advice. Goldfish raising, mused Rice, that is something different. But he was prepared to tackle it.

He and Underwood sized up the situation. Was there a market for goldfish, they pondered. How expensive would it be to put such an enterprise in operation? Also, was technical advice available?

These questions worried Rice and the counselor until they found the answers. First, there was a market, because goldfish were bait with an appeal to certain fish, namely crappie, catfish, and bass. These fish abound in the lakes and streams of Eastern Arkansas where the goldfish project would be located.

It was ascertained that fishermen would snatch up the goldfish by the thousands once they learned Wiggins had them for sale. But, what about the expense of digging ponds for the fish? And, water, that was another question.

It was determined by Rice that 12 ponds could be dug for less than Wiggins would earn in his first year. On his 20-acre tract of land there was an underground well capable of providing an ample supply of water to fill the ponds.

Mr. Kerr is Information Officer for the Arkansas Rehabilitation Service.

That left the question: Who could furnish technical advice for the project? The investigators found that a man who lived in another county had achieved success in goldfish raising and that he was willing to offer assistance to the young man. However, responsibility for the project remained with Rice and Underwood.

Excavation for the ponds was started late in 1971 and completed in December. The work included installation of 10-foot sections of pipe to form a system whereby Wiggins could drain his ponds on a rotating basis to obtain fish for the sale pond. His brood stock was purchased from the man who had helped with technical advice.

In the spring of 1972, Wiggins was ready to make his first sales. During the months of May and June he racked up sales totaling over $100, which exceeded Rice's initial year expectations. From now on sales will continue to climb and augment Wiggins' income, which also includes earnings from a job at an oil company bulk plant.

More in keeping with Rice's agriculture background is the enterprise he helped Levi B. White set up in 1970. In that year, rehabilitation counselor Roy W. Hartwick, wrote a rehabilitation plan for White, who had service-connected arthritis. The plan provided for a cattle-raising enterprise with the rehabilitation agency providing a starter herd of 20 heifers and a bull and feed for the animals.

Through an inheritance, White had access to 90 acres of grassy land. This provided the cattle a place to graze. He also had a barn for shelter for his herd during periods of breeding. A house located on the land provided his family with a dwelling.

Since the start of his project, White has acquired 10 more animals and is learning the technicalities of cattle raising by attending an agriculture school under the GI bill. As of mid-July, his herd of Brown Swiss-Hereford and Brahma-Holstein numbered 30.

The first calves from White's herd will be born in October. He can, if he chooses, sell the calves to supplement his income from part-time employment. A 3-day calf will bring $60 to $75, but White's present planning is to continue adding to his herd and develop beef animals for the market.

But for Rice there will be others. His job description is broad enough to cover many facets of agriculture. For example, on a couple of occasions he has assisted disabled persons in the raising of guinea pigs for research animals. More successful have been rabbit projects, as well as feeder calves and feeder pig projects.

The raising of quail has proven profitable in some instances, as has the planting of hay and pasture grasses. On one occasion, Rice helped a rural dweller set up a molasses making project. Beekeeping is another farm-type enterprise Rice and a rehabilitation client have tried with success.

Rice sees each referral sent to him by rehabilitation service counselors as a new challenge. "Each and every referral presents a different set of circumstances and all human and material resources, likes and dislikes, capabilities and disabilities are important factors in the rehabilitation process of the clients we serve," Rice said.

He has prepared a three-page list of possible rural self-employment projects, which he goes over with each new client. From the list of some 110 possible projects the client can select the one he is interested in. Then, upon investigation of all the variables connected with the case, Rice and the client's counselor and his supervisor make a determination.

The types of projects Rice has found most successful for rehabilitation clients include feeder and slaughter calves, replacement heifers, poultry layers, feeder pigs, rabbits, guinea pigs, commercial fishing, worms, peanuts, and hay and pastures for livestock.

He even has such activities as raising tropical fish and the production of cowpeas listed as possible projects. But Rice apparently has no present plans to branch into those particular enterprises.

Levi White and part of herd VR helped purchase.

West Virginia Agency Serves Flood Survivors

Ann H. Garcelon

Buffalo Creek Dam Bursts Causing Flood

Saturday, February 26, 1972. The dam at Three Forks at the head of Buffalo Creek, Logan County, West Virginia gave way this morning, unleashing millions of gallons of water—a 30-foot-high wall of water—which raged through 16 communities along the creek. There are countless deaths. Injuries and destruction of homes are inestimable at this time. Other flooding has been reported in Logan and Mingo Counties.

THAT WAS THE NEWS on that cold, bleak, February morning. Entire communities—Pardee, Lorado, Lundale, Amherstdale, Becco, Accoville, to name a few—were washed away as the floodwater ran its course down the 15 miles from the dam to where Buffalo Creek empties into the Guyandotte River at Man, West Virginia. One hundred and eighteen persons lost their lives, scores were injured, some 30 persons are still missing or unaccounted for, and over 4,000 were left homeless. Property loss ran into the millions. Virtually nothing was left of the valley where coal-mining towns once prospered.

A massive relief and recovery effort was begun the same day, with State and Federal Government agencies, the West Virginia National Guard, the Army Corps of Engineers, the Red Cross, Salvation Army, and other private or-

(1st photo) the devastation. (2d photo) Counselor Sisco inspects site of client's home. Wheelchair ramp is all that remains.

Ms. Garcelon, formerly a counselor for West Virginia's Division of Vocational Rehabilitation, is now assistant chief of information and editor of the DVR quarterly publication, COMEBACK.

ganizations—as well as countless volunteers—joining forces.

Recognizing the fact that many persons in Logan and adjacent Mingo County were in need of vocational rehabilitation services as a result of the flood, the West Virginia Division of Vocational Rehabilitation (DVR) reacted quickly in mustering its forces to provide these services. Within 3 days after the rampaging waters virtually wiped out the 15-mile valley, DVR had set up field headquarters in the Appalachian Regional Hospital at Man. For several weeks, the rehabilitation field office was kept open 7 days a week to provide rapid services in the most convenient manner.

By Sunday—one day after the ravaging flood wall swept down the valley—planning for DVR's recovery operation was underway. Mullens District Supervisor Cecil E. Lacy, whose district includes Logan and Mingo counties, advised State Rehabilitation Director Thorold S. Funk of the proportions of the disaster and the need for rehabilitation services for survivors. After a meeting of key staff on Monday morning, February 28, Funk ordered the establishment of the Man field headquarters. Division staff members were alerted to be ready to provide rehabilitation services as soon as funds were available.

William A. Crunk, Associate Regional Director, HEW, arrived from Philadelphia on Tuesday to head up the total disaster relief effort of SRS agencies in West Virginia. In this capacity, he served on the Governor's Disaster Relief Committee and was in daily contact with West Virginia Governor Arch A. Moore, Jr. Meeting daily with the heads of various SRS agencies, Mr. Crunk assisted them in planning for their roles in the recovery operation. He was of special help to DVR in preparing an application for an RSA expansion grant. By Thursday, the plan had been completed and approved, making available more than $100,000 in additional rehabilitation funds for the disaster area. [A like amount has recently been awarded to the State DVR in South Dakota to aid in the recovery process for disabled clients in that flood-ravaged area of the country.]

Initially, the Man field headquarters, under the direction of William Robertson, senior counselor in the Logan branch office, was concerned with obtaining referrals of flood victims. Rehabilitation counselors, in cooperation with hospital personnel, screened all hospital admissions for possible referral to vocational rehabilitation. Also, at this time, every effort was being made to account for the 45 clients in the area who were on DVR rolls at the time of the flood. Division case records were made available to personnel involved in identifying bodies in those cases where no other medical information could be obtained.

By Thursday, March 2, recovery operations by the military and civilian agencies had progressed to the point that rehabilitation counselors from the Logan, Mullens, and Williamson offices were able to begin their door-to-door survey of the remaining houses in the valley for survivors in need of rehabilitation services. Reports were received that many survivors from the upper reaches of the valley had traveled across the mountain on foot to neighboring Boone County and that a temporary shelter had been established at Wharton. Lacy and a team of counselors traveled to Wharton, where 200 people had sought refuge, to identify possible rehabilitation referrals.

As the situation began to stabilize through the efforts of the recovery forces, increasing numbers of persons began coming into the Man field headquarters and the Logan branch office.

In recounting some of the actions taken to find victims in need of services, Lacy stated that "every possible means of communication at our disposal was used." He pointed out that signs made at the West Virginia Rehabilitation Center's sheltered workshop were "invaluable" in directing the refugees to the Man field headquarters. Identification tags were distributed to all counselors working in the disaster area. An agency station wagon with Vocational Rehabilitation painted on its sides was used to travel up and down the flood-scarred valley.

All the usual rehabilitation services were made available to flood victims. In addition, any individual who had lost any type of prosthetic device, hearing aides, teeth, glasses, upper and lower limbs, braces, and wheelchairs, was able to have them replaced by the division, by swiftly and painlessly going through the rehabilitation process.

Contacts were made daily with the Red Cross, Salvation Army, Department of Welfare, and other relief agencies to identify possible rehabilitation referrals and to coordinate joint efforts being made to restore order to the devastated area.

By the beginning of the next week most of the initial recovery work had been completed and the military forces were being with-

drawn. Mobile homes, provided by the Department of Housing and Urban Development (HUD) as temporary homes for the flood victims, were arriving. As each mobile home community was established, counselors visited homes in search of persons needing services.

Division personnel met with HUD and Red Cross officials to discuss structural barriers problems which were becoming evident in the relocation of some of the DVR clients. Provisions had to be made in regard to adapting the mobile homes to meet the needs of some of our clients in the area. Changes had to be made in the entrances to the trailers and in the bathrooms. Arrangements were made with a group of Mennonite workers from Virginia to build ramps to several mobile home entrances. Under the guidance and supervision of the DVR, the Mennonite workers constructed the ramps with supplies purchased by HUD. The West Virginia Department of Highways provided slate and fill dirt to build the ground level up to ramp specifications.

The challenge presented by the enormity of this disaster was accepted by the West Virginia Division of Vocational Rehabilitation. Through its determination and dedication to serving handicapped people, it was able to translate standards and regulations into immediate action. Rehabilitation services were provided to more than 350 flood victims.

In commenting on the division's role in the recovery, Lacy said that the early face-to-face contacts with the survivors cannot be discounted. As an example, he told of a woman contacted at the Wharton refugee center who had lost her artificial leg in the flood. Two days later she showed up at the Man field office, where steps were taken to get her a new limb.

"Like so many others," Lacy said, "she lost everything in those few awful minutes on the morning of February 26. Getting her a new leg isn't very much when you consider all she lost, but that's our job and we're glad we could do it."

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DEVELOPMENT OF A MODEL FOR VOCATIONAL EVALUATION OF THE DISADVANTAGED. (RD 55140) Auburn University, School of Education, Auburn, Ala. 36830. 76 pages.

They Hit

Tom Brubeck

The man sat in the diner's corner booth, forgetting his coffee and the small tape recorder on the table.

"Let the fact that you're caught, convicted and sent there be punishment," he said, "and then spend the time in prison preparing the guy to be a good citizen when he gets out."

His theory was obtained at close range. The man was an ex-convict, paroled one hot day in 1970, and he was talking to another ex-convict. This was one of 60 interviews taking place throughout San Diego County as part of a study to determine how parolees view their own rehabilitation needs. Six specially trained ex-convicts served as interviewers and also helped select the questions and interpret the results.

The study was conducted by Western Behavioral Sciences Institute of LaJolla under a grant from HEW's Social and Rehabilitation Service. The findings for such projects are disseminated to State and local agencies by research-utilization specialists in SRS regional offices, as well as through seminars, professional journals, and mass media.

According to the report, the parolees' needs are basic: education, money, job, and training were the highest ranked needs of those surveyed. Similarly, the three greatest concerns of ex-convicts are: not using their abilities, lack of money, and inadequate education.

Although the men are confident of succeeding on parole, a third of them circle back to prison. The principal investigator, Wayman J. Crow, Ph. D., says the research project shows, first, that parolees have acute physical and material needs. "They leave prison with a few days' money and a lifetime stigma," he says. "They have neither the personal support that comes from others in marriage, as members of work groups, and from relatives, nor are they connected with social groups. The ex-convicts have middle class values and put much stress on hard work and self-restraint. They are searching for ways to become connected with the larger community."

Parolees are out of touch with society for years. The research points out that half of them do not return to their home communities. Only a quarter of the men are married. "Emergency" funds available for parolees are small—$40 to $80. "Prisoners look forward to getting out," says Dr. Crow, "but they have to hit the street running, and many have little or no help."

When asked what it was like the first few days out of prison, a third of the parolees reported "far out," "sweet," and other positive reactions. But responses from half of them were negative. They felt lost, lonesome, depressed, unsure, or paranoid. One man said, "The best way to describe getting out is what it would be like for a cat that's been penned up all the time. Let it out and it sees a mouse, and it don't know whether to catch it or run from it."

Several talked of the unfairness of a stigma. One said, "I've got the work experience, but being an

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Mr. Brubeck is a technical writer for the Office of Public Affairs, SRS.

Archie Connett, an ex-convict and Western Behavioral Sciences Institute staff member, originally designed the study. The report (15–P–55287) is titled, An Offender Looks at His Own Needs, *R. J. Erickson, W. J. Crow, L. A. Zurcher, A. V. Connett, and W. D. Stillwell.*

The Street Running

ex-con is putting the hang-up on me. They make it so hard for a person to make a decent living." Another said, "Try to understand the man, and know one thing for sure, that because they've committed a crime, it doesn't make them less than a man."

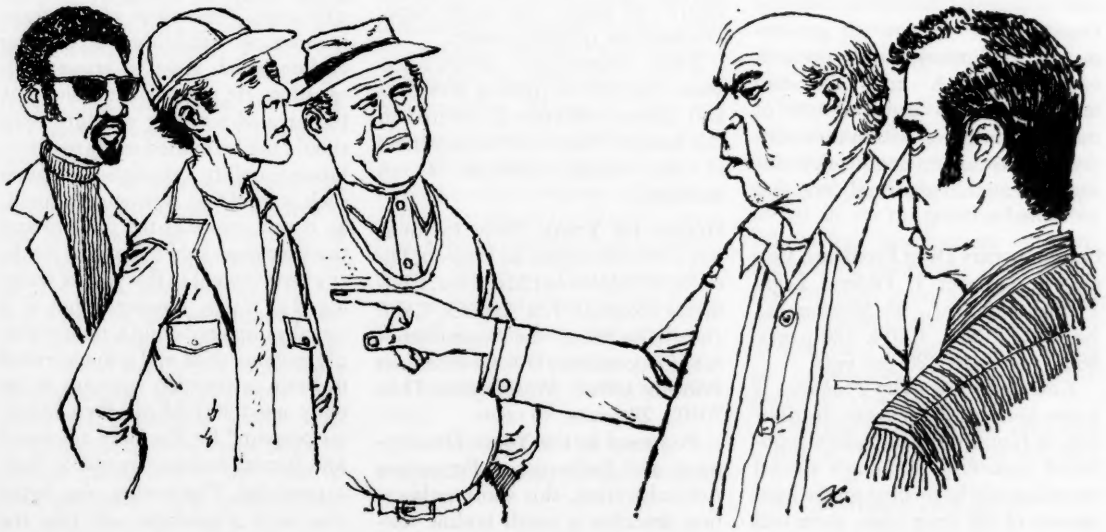
One man says that parole officers should make it clear what parolees should do to stay out of prison. "What they don't realize," he said, "is that us guys are used to being talked to like 'Button your shirt, put your collar down, tie your shoes, sit down, stand up, shut up, line up, lock up'—the whole bit. So why do they have to soft-soap us when we hit the street?"

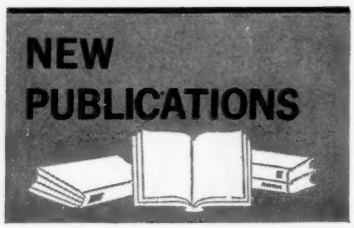
Dr. Crow suggests that the needs and values of ex-convicts are no different from the average law-abiding person. Most of them appear to be "middle class people without money." He continues, "The popular myth that the criminal has rejected society's values, that he is forever a public enemy in the sense of not sharing the orientation towards the world of the law-abiding general public is contradicted by these results."

Louis Zurcher, Ph. D., a research associate in the San Diego project, reports that in their self-concepts parolees are "adrift from social moorings." He says they seem to be searching for a place where they can take a social stand, where they will be accepted and understood, and where they can find their way like other human beings who do not happen to be ex-offenders. "But they didn't know where to take that stand, nor how to take it," says Dr. Zurcher. "Some of them were anxious that if such a path did not appear, they'd find themselves back in the joint."

The study recommends that a released prisoner—high on hope and low on resources—should receive enough money to give him a fair chance of making an adjustment, be eligible for unemployment benefits for 6 months, and have full educational and vocational opportunities. To remain outside of prison walls, the words that summarize the parolee's needs are money, education, and social ties.

". . . us guys are used to being talked to like 'button your shirt, put your collar down, tie your shoes, sit down, stand up, shut up, line up, lock up' . . ."





International Directory of Mental Retardation Resources. Rosemary F. Dybwad, Ph. D., editor. The President's Committee on Mental Retardation, Washington, D.C. 20201. 316 pages.

Mrs. Dybwad, the compiler and editor of this volume, is a research associate at the Florence Heller Graduate School for Advanced Studies in Social Welfare, Brandeis University. The study was supported, in part, through a National Institutes of Health grant.

The work is broken down into two parts, with the first discussing programs of international organizations and the second surveying programs in 58 individual countries. Under the international aegis, for example, the work of UN agencies (UNICEF, ILO, WHO, and others) and inter-governmental agencies are among the programs discussed.

The State entries cover such material as a short historic, geographic, and economic description of the country and listings of governmental, voluntary, and research organizations. A brief narrative section describes many aspects of mental retardation within the country, such as case finding, work training, education, residential care, and personnel training.

Contemporary Drug Problems, Volume I, Number I. Federal Legal Publications, Inc., 95 Morton St., New York, N.Y. 10014. 180 pages. $6.50 per copy, $20 per year.

Contemporary Drug Problems is a new journal which began distribution in January 1972. It will be published quarterly. Although special attention will be focused on the legal aspects of the drug crisis, there will also be a forum for educators, social workers, psychologists, doctors, school administrators, sociologists, and all concerned citizens to examine the legal, social and medical impact of drugs today.

Regular features of the publication include a digest and analysis of recent significant cases and a round table session on a specific theme. The first of these, "Methadone Maintenance: Pro & Con," probes such topics as the "welfare addict" as an extension of the drug epidemic and the incipient black market in methadone.

Retarded Children of the Poor. Marjorie H. Kirkland, M.S.S.W. SRS Publications Distribution Center, Room G–115–B, HEW South Bldg., 330 C St., S.W., Washington, D.C. 20201. 66 pages.

This publication deals with families that have problems of retardation, and are heavily represented on welfare rolls: the mildly and borderline retarded, whose appearance and behavior are usually not grossly different from the "normal," but whose behavior is often frustrating to the worker. Six case studies are presented. A list of suggested readings is included.

Anatomy of Ostomy. United Ostomy Association, Inc., 1111 Wilshire Blvd., Los Angeles, Calif. 90017. 20 pages. 50¢ single copy. Discount on quantity orders.

Basic anatomical information about the various types of intestinal and urinary ostomies is covered in this booklet. Care and management of the various ostomies is not included.

Hotline for Youth. Betty Jo Johnson, Director of Special Projects, Division of Adolescent Medicine, Children's Hospital, Los Angeles, Calif. (available from) the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402. 28 pages. 30 cents.

Presented by the Youth Development and Delinquency Prevention Administration, this short publication describes a youth hotline telephone service; it uses as a guide one such "crisis intervention resource" system already established in the Children's Hospital in Los Angeles.

Although the monograph does not list systematic steps necessary for organizing a hotline for young people, it does outline the structure, funding, and purposes of such an operation. In addition, the booklet provides a description of staff recruitment and training. It also considers a very important aspect of the hotline—the "person who is as immediately available to a troubled youth as the nearest telephone"—the listener, the counselor, the friend.

The last section of this publication deals with particular telephone situations and problems—it presents various listening techniques and attitudes which might help the listener find the most effective way to communicate his or her understanding and sympathy to the young caller.

The Role of the Resource Teacher in Mobility Instruction. Thomas M. Trevena. Alameda County School Department, Curriculum Library, Room 190, 225 West Winton Ave., Hayward, Calif. 94544. 15 pages. $1.

What can a resource teacher do for a blind or visually handicapped person in the field of mobility instruction? The author of this short monograph establishes a guiding outline which seeks to answer this question. He presents his belief that the area of teaching mobility skills should not be limited solely to orientation-mobility specialists. Being such a qualified instructor himself, he is well aware of the positive and negative aspects of a resource teacher's involvement in this type of training. He states, however, that if a visually impaired child is taught simple mobility skills and is made aware of basic orientation concepts at an early age, the child will then be better prepared for the more advanced and formal training available from a specialist. The author also hopes that such a specialist will take the

outline provided in the booklet into serious consideration as a systematic approach to teaching remedial or beginning skills in orientation and mobility.

Rehabilitation in Community Mental Health. H. Richard Lamb and Associates, Jossey-Bass Inc., Publishers, 615 Montgomery Street, San Francisco, Calif. 90411. 204 pages. $8.75.

Psychiatric rehabilitation within the community is an idea whose importance and need is becoming increasingly apparent. A clear summary statement of the authors' participation and experiences in such a community rehabilitation movement is set forth in this book. Basic concepts are presented; the reader is then introduced to various detailed aspects of sheltered workshops, sheltered work placements, therapeutic housing, social rehabilitation, and rehabilitation counseling.

In the book's appendix the reader will also find a guided description of the role of a workshop foreman.

The book itself is designed as a practical guide to psychiatric community rehabilitation for both students and practitioners.

The Practice of Social Intervention: Roles, Goals, and Strategies: A Book of Readings in Social Work Practice. Frank M. Lowenberg and Ralph Dolgoff, editors. F. E. Peacock Publishers, Inc., 401 West Irving Park Rd., Itasca, Ill. 60143. 505 pages. Hardcover, $10. Paperback, $5.95.

Prepared as resource material for teachers and students, this publication brings together a wide array of readings dealing with different aspects of social intervention. The varied selections find a common bond in the expressed conviction that ". . . social work's task is far more than mending society's little mistakes. While helping people with problems, social workers are ready to address themselves to the roots of these problems." The book reveals a "balanced mixture" of critical thinking and farsighted planning which is needed to approach and deal with the many social troubles.

The 46 selections are grouped into general divisions entitled: (1) social geography, (2) goals for social intervention, (3) social services, welfare colonialism and community control, (4) social intervention systems: agencies and people, and (5) social intervention strategies: levels, targets, roles.

The many questions which are raised and discussed in this collection of essays provide readers with an understanding of the various strategies, developments, and goals being established in the field of social intervention.

Communication Problems After a Stroke. Lillian K. Cohen, M.A. Kenny Rehabilitation Institute 1800 Chicago Ave., Minneapolis, Minn. 55303. 23 pages.

Once a stroke victim returns to his home environment, his family is confronted by many disturbing problems, all of which call for immediate, personal adjustments. One of the most staggering difficulties facing the entire family is found in the patient's impairment of speech.

The Kenny Institute rehabilitation publication provides simple, concise explanations of the many communication problems (speech disturbance, automatic speech, word substitution, writing and reading difficulties, inconsistency, and visual trouble). Although these explanations are of a general nature—recognizing that no two patients will have the same language disabilities—they do afford the family with a better, more rational understanding of the situation. The communication problems discussed in the booklet will, in turn, help the stroke victim's family cope with the problems and maintain itself throughout the crisis.

Development of this monograph was made possible through support of SRS.

Who Cares about the Alcoholism Program in the General Hospital? American Hospital Association, 840 North Lake Shore Dr., Chicago, Ill. 60611. 49 pages. $1.50.

Alcoholism is an acute illness which afflicts a large percentage of the population. Although there are many rehabilitation programs instituted to help the alcoholic patient, these projects do not totally satisfy the actual need.

By responding to the searching questions and by studying the revealing answers, which make up this short monograph, general hospital administrators should discover a great deal about their own existent or nonexistent programs. The publication is, in effect, a reminder directed by the American Hospital Association to general hospitals with regard to their responsibilities toward alcohol and other drug problem patients.

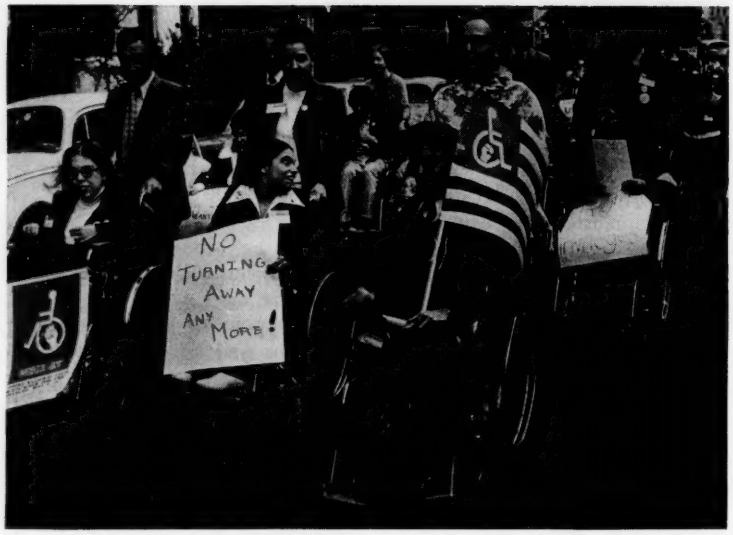
Fun is Therapeutic. Ardis Stevens. Charles C Thomas, 301–327 East Lawrence Ave., Springfield, Ill. 84 pages. $6.50.

The recreation leaders who contributed to the making of this book believe strongly that fun and recreation are indeed therapeutic. The many ill, aging, and handicapped people who spend a large part of their lives in homes, institutions, and hospitals need various diversions to assure themselves a necessary amount of well-being and happiness.

Individuals working in a recreational capacity with persons who are institutionalized, hospitalized, or homebound should find this book useful in its provision of detailed listings and explanations of many therapeutic programs. These activities include musical games and dance therapy, nature related activities, card playing, simple crafts and dramatics, and imaginative games in general.

The book includes not only this wealth of fun ideas, but it also pre-

(continued on page 26)



The disabled march in Washington, D.C. in May 1972.

Disabled People

Patricia J. Thoben

In a day and age of active expression by Americans on the many social, political, and economic issues affecting human rights, a unique minority of citizens raised their voices in an attempt to awaken the collective consciousness of America to the needs and concerns of the physically and mentally disabled.

May 5–13, 1972, was set aside as National Civil Rights Week for the Disabled. The first structured activity took place in Washington, D.C., May 5, 1972, National Advocacy Day. A demonstration of disabled citizens began with a 6-mile march from the Washington Hilton Hotel on Connecticut Avenue, and ended with a rally at the U.S. Capitol. The objectives were to deliver a proclamation to Congress and to stimulate public awareness of the unmet needs and problems of some 44 million physically and mentally disabled Americans.

Ms. Thoben is Assistant Chief, Program Evaluation Branch, Division of Developmental Disabilities, Rehabilitation Services Administration.

This demonstration originated from several organized groups of the disabled: Disabled in Action, Disabled in Coalition, Spina Bifida Association of New York, National Association for the Physically Handicapped, Pride, and Handicapped Students Association. Many of the marchers were members of one or more of these groups that had ended a week of participation in a national meeting of the President's Committee on Employment of the Handicapped.

In addition to these organizations disabled employees from the U.S. Department of Health, Education, and Welfare, the Center for Concerned Engineering, a Nader organization, and other private citizens from the Washington Metropolitan Community participated.

There were 100 disabled marchers in the 6-mile uphill hike which began at 9:30 a.m. and ended with a rally on the west Capitol steps at 12:30 noon. The Washington Metropolitan police with a scooter patrol of about 10 escorted the group along Connecticut Avenue and down Constitution Avenue to the Capitol.

Some 20 volunteers were on hand to assist in pushing wheelchairs, to offer first aid attention as needed, and to assist in pushing aside construction barriers. Traditional civil rights chants were heard, such as "We Shall Overcome." Posters of "Dignity Not Pity," "Fair Housing Not Institutionalization," "No Turning Away Any More," "We don't want to go to the Moon—Just across town on the Metro," and "All People are Equal" were carried. Literature describing the objectives of the march was distributed.

At the Capitol Hill rally organizers of the demonstration who were in wheelchairs were carried up the steps for their speeches. Only one Congressman, Senator Harrison Williams (Democrat—New Jersey), was present to express his interest and to give his vote of confidence to the group. Senator Williams has proposed legislation for establishing an office for the disabled within the DHEW as well as a White House Conference on Disability. (These were two, among many, propositions that the marchers espoused.)

There was minimal press coverage, with short articles in *The Washington Post* and *The Evening Star.* Local television (Channel 4) reported the activity briefly.

For more than a decade civil rights movements have set the stage in America for concerned citizens to be heard. The climate has been established, and minorities now speak forth and demonstrate to effect change.

The disabled are a large minority group which most people would not expect to take such a dramatic step. The overprotective, apathetic paternalism of our nation has been so

March For Civil Rights

complete that the declaration of a National Civil Rights Week and a National Advocacy Day with a march and rally was met with mixed reactions by disabled and nondisabled alike.

The civil rights concept has become equated with only racial minorities and for another minority of citizens outside of the defined parameters of the equal rights movement to take hold of this banner was a challenge not only to civil rights advocates but to every individual who does not understand the needs and problems of the disabled.

Obviously to apply the label of discrimination to the disabled was unheard of, and yet the emotional reaction to a visibly impaired physique is no different from the same reaction to color or sex. Thus, the same inequities exist—although perhaps in a somewhat different way.

Organizers of the demonstration extended invitations to all Congressmen to participate in the rally. Further personal invitations were extended to a number of Senators and Congressmen who have introduced legislation concerned with the problems of the disabled, as well as leaders of federal programs for the handicapped, national consumer organizations, and presidential committees.

One wonders how men can legislate, advocate programs, and plan and implement these programs intelligently, with sensitivity, to the realities of the situation without participation?

The 100 marchers were enthusiastic and strongly determined in their demands for equal rights under the law. When one sees a young man severely disabled with cerebral palsy push his wheelchair backwards with only his feet for 6 miles uphill without assistance; a young woman on crutches who could not stop to rest for fear she wouldn't be able to continue; another man, his body totally paralyzed except for some slight finger movement, manage his electric wheelchair—is there any doubt about the urgency of their cause?

Not all disabled people were as determined. Although concerned in their hearts, they were unable to expose themselves in a public expression of their convictions. Some of this is due to apathy, especially in those individuals disabled in service-connected activities who are now receiving government pensions. Feelings of insecurity were expressed that there would be a great let-down or depression because nothing significant would change—a more complex reaction for nonparticipation.

Excuses that the marchers were radicals, exhibitionists, and troublemakers frustrated by their disabilities were made for nonparticipation. Perhaps—but not really. They were radical, yes, because they dared to expose themselves publicly to concerns brought about by the frustrations due to disability and society's reactions toward their disability. Exhibitionists, yes, exhibiting real sensitivity and concern for human dignity. Troublemakers, yes, if that term is used to mean individuals who care enough to make waves in a depersonalized society.

Although one can only conjecture with respect to the man on the street or those observing from windows in government and business offices along the way, one was almost deafened by the meaningful silence as the 100 "different" demonstrators chanting "civil rights now" passed by. A busload of touring boys and girls, 10 to 12 years of age, was most eagerly spontaneous in their request for the literature marchers were distributing.

The hard facts and reality behind this demonstration are the violation of the human rights of 44 million disabled citizens. Equal educational opportunities do not exist due to architectural barriers, discriminating admission policies in schools and isolation due to overspecialization. If an education is achieved, work opportunities are difficult at best. Many disabled are not able to obtain jobs related to their abilities and seldom receive a pay level compensurate with the nondisabled. Dis-

crimination is a result of ignoring qualifications in light of disabilities unrelated to job performance.

Public transportation is nonaccessible to many disabled, and other public carriers are either too exhorbitant in price or too indifferent to assist when it is needed.

Housing, public or private, is another area where the disabled are excluded because of architectural barriers and discrimination by landlords. Many are denied use of public streets due to high curbs; denied access to theatres because their very presence in a wheelchair or on crutches constitutes a fire hazard; denied the right to test drive a car before purchasing it because of the need to use a hand control; denied access to airlines because the carrier cannot accommodate a wheelchair; denied the protection from economic exploitation of medical needs from high prices of drugs and special equipment.

Civil rights legislation is not a utopian solution but it is a most effective mechanism for protection of our rights under the Constitution. To date we have no assurances of equal protection and treatment under the law.

Compared to a similar demonstration in London (where 600 disabled people demonstrated—see *Rehabilitation Record,* November-December 1971—and obtained, within a relatively short time, additional services through Parliamentary legislation) there has been significantly little by way of results from all sectors of society. However, this was only a beginning. The spirit of a few determined disabled individuals to accept the responsibility of their own destiny—of realizing their hopes of participating in a society in which *all* are equal to live and participate—should bring about a new awareness. Let us hope that society will begin to accept its responsibility and not retreat with guilt through apathy and will participate with understanding, and *concern for equality for all its members.*

NEW PUBLICATIONS

(continued from page 23)

sents the professional therapist or volunteer worker with a guide to the theories and methods employed in such rehabilitative activity.

Retirement. Frances M. Carp, Ph. D., editor. Behavioral Publications, 2852 Broadway, Morningside Heights, New York, N.Y. 10025. 408 pages. $16.95.

This comprehensive study on the psychology of retirement is an outgrowth of the editor's work at NIH combined with several years of conferences, study, and research on the part of 37 other associated specialists. The analysis was instituted in order to provide direction for federal programs concerning retirement and aging, and also to initiate the development of theories in this neglected area. The conclusions reached by this study state definitely that retirement is not the last step in the course of human development, rather it is an important transitional stage in life.

The book provides a nontechnical analysis which can be used as a good source for further research and particular study. It is written from the viewpoint of various authorities on different aspects of human development including sociology, anthropology, psychology, psychiatry, medicine, and economics.

Child Care Quarterly. Jerome Beker, editor. Behavioral Publications, Inc., 2852 Broadway, Morningside Heights, New York, N.Y. 10025. Published quarterly in October, January, April, and July. Subscriptions—$10 per year (individuals) $20 per year (institutions).

Child Care Quarterly is a new professional publication designed to provide helpful information for those who work with and care for children in centers, institutions, and residential settings. The first issue contains a number of articles dealing with child care workers, therapy, day care centers, and child care in general. Included as regular features are reviews of books and related articles and various news items from the field of child care itself.

Attitudes Toward Blind Persons. American Foundation for the Blind, 15 West 16th St., New York, N.Y. 10011. 74 pages. $2.

The American Foundation for the Blind presents this publication as ". . . a first step in a long term program to find rational ways of dealing with an irrational problem—discrimination against blind persons." This prejudice which pervades much of our modern society is a tragic reflection on our concept of humanity. The reports and reactions expressed in this booklet are designed to bring an awareness to the general public—an awareness which would open their eyes to the reality of the negative attitudes affecting blind people. Progress can be made, or at least expected, only when the magnitude of the problem is fully realized by everyone in this country. The contents of this publication should provide a direction and a necessary stimulant to bring about such progress and change.

The book is an outgrowth of the Foundation's 50th Anniversary Symposium on Attitudes Toward Blindness. The symposium was held October 28 and 29, 1971. The papers, reports, and reactions by various authors are reflections of the symposium's goal, which is to design a methodology for use by local communities to translate the "realities of being blind in today's society in order to create a more realistic awareness and acceptance of blind persons, and to develop a body of knowledge that could be exploited on the local level."

Weight Control For Handicapped Adolescents

Spencer F. Brown, M.D.

Nancy F. Erdle

Obesity is an important problem among adolescents, especially since there is evidence[1, 2] that it leads to obesity in adult life. It is an even greater problem for handicapped adolescents. An excess of weight makes locomotion more difficult for the patient, and it adds to the labors of those who help care for him. Its frequency among handicapped adolescents enrolled in three physical rehabilitation centers in Iowa in 1971 ranged from 19 percent to 40 percent.[3]

During the 1970–71 school year we undertook a weight control study at the University Hospital School, a residential rehabilitation facility, at the University of Iowa. All of the 13 subjects were orthopedically handicapped. There were seven overweight subjects ranging in age from 13 to 19. Six adolescents of normal weight, aged 17 to 19, served as controls. Height, weight, and triceps skinfold thickness (method of Seltzer and Mayer[4]) were measured on all subjects at the outset of the study. Thereafter weight and skinfold thickness were measured weekly on the obese group and monthly on the control group.

Of the seven in the study group, three were above the 80th percentile in weight on the Iowa growth charts. They were placed on a daily diet of 800 calories. The other four fell between the 50th and 80th percentiles and were placed on a 1,000 calorie reduction diet. The 800-calorie diet was selected because the energy consumption of these subjects was very low. We felt that giving less than 800 calories would only encourage the tendency to cheat on the diet, a stumbling block for all who attempt to reduce weight. The four subjects on the 1,000 calorie diet were less obese, and their activity was greater. The control group was served a regular diet of approximately 2,000 calories.

Dr. Brown is Associate Professor of Pediatrics, University of Iowa, College of Medicine. He is also in charge of adolescent patients at the University Hospital School. Mrs. Erdle is a former therapeutic dietician in the Department of Nutrition, University Hospitals, Iowa City, and is now therapeutic dietician, Middlesex General Hospital, New Brunswick, N.J.

We used the "total push" technique in this weight reduction program. In order to get the optimum interest and cooperation we began with the individual subject. In a conference with Mrs. Erdle the subject's feelings about his weight were discussed, and a weight goal was agreed upon—one which involved enough loss of weight to make a significant contribution to the adolescent's total rehabilitation program and would be well within a realistic expectation of achievement.

We enlisted the help of many members of the Hospital School staff. The nurses and the aides and orderlies working under their supervision were brought into the effort and gave enthusiastic help. Two medical social workers and a physical therapist ate at least one meal a day during the week with the study group and often another on weekends when fewer staff members were available. They added interest and motivation to the program by their encouragement and the example of their own weight loss. The physical therapist also tried to increase the activity of the study group by encouraging them to walk, if possible, instead of using a wheelchair. He prescribed appropriate exercises for each patient.

The weight chart for all patients and staff participating in the study was prominently displayed in the dining room. The weekly weights were entered on the chart. The subject who lost the most weight was honored each week with a red circle at his place on the chart. A black circle called attention to the subject who lost the least weight or who gained.

The study subjects were given individual dietary counseling by Mrs. Erdle. This included such matters as how physical activity affects caloric need, the nutrient value of various foods, the caloric value of foods, and how to manage problems arising on special occasions such as eating outside the Hospital School or at parties. Dr. Brown counseled the subjects on the medical and physical reasons for weight reduction. Whenever parents of any of the study subjects came to the Hospital School they received the same dietary counseling their child had been given. In addition methods of food preparation were discussed. Parents were encouraged to avoid having snacks available while the child was at home.

We thus tried to involve everyone who came in contact with the obese patients so as to arouse and maintain interest, enthusiasm, and cooperation in the weight reduction program. We also tried to avoid negative reactions by not overdoing our efforts.

We were not entirely successful in our efforts to persuade all members of the staff of the importance of the weight reduction program. The problems varied. A staff member might feel that some of the subjects were "not fat," and he would permit them extra food. The study was done in Iowa, where weight, as such, seems to have positive social value, and obesity incurs little disapproval. The normal

Table 1

Weight change and performance index for study group

Subjects	Observed weight change in pounds	Weight loss goal	Performance index (Percent of goal achieved)
800 Calorie Diet:			
JB	−13. 5	−14. 5	+92
TG	−27. 5	−45. 5	+60
AO	−29	−57	+51
1,000 Calorie Diet:			
SC	−4. 0	−9. 5	+42
TF	+12. 5	−4. 0	−313
RS	−10. 5	−14. 0	+75
MZ	+1. 5	−4. 0	−38

Table 2

Observed weight change in the control subjects

Subjects	Observed weight change in pounds
JD	−1. 0
DH	+1. 0
VM	+7. 0
BO	+3. 8
WS	−9. 0
RD	−2. 5

Table 3

Change in triceps skinfold thickness using the classification of Montoye et al. [6]

Subjects	Thickness in millimeters beginning	Thickness in millimeters end	Beginning percentiles	End percentiles
Study Group				
800 Calorie Diet:				
JB	24. 5	19. 0	80	50–80
TG	15. 0	9. 0	50–80	20–50
AO	18. 5	14. 0	80	50–80
1,000 Calorie Diet:				
SC	18. 0	15. 0	50–80	20–50
TF	16. 5	23. 5	20–50	80
RS	15. 5	12. 0	20–50	20
MZ	5. 0	5. 0	20	20
Control Group				
JD	5. 0	5. 0	20	20
DH	3. 0	3. 0	20	20
VM	18. 0*	18. 5*	80	80
BO	25. 0*	25. 0*	80	80
WS	9. 0	8. 5	20–50	20–50
RD	5. 5	5. 0	20	20

*Subject could not relax arm.

turnover in personnel often meant there was not time to educate new staff members in the importance of the weight loss program. Evening and weekend recreation programs presented special difficulties. Patients were taken out of the Hospital School building for shopping trips, concerts, and other special events. On these excursions they were supervised by university student volunteers. Despite our best efforts, it proved impossible to inform all these recreation volunteers of the nature and importance of the diet program. Consequently hundreds of unplanned-for calories were consumed on these trips.

RESULTS

Each patient's energy output was estimated. His basal energy requirement was estimated from the Boothly and Berkson Food Nomogram.[5] These figures determined the daily calorie deficit. The weight loss for each week was predicted, based on a loss of 1 pound for each 3,500 calorie deficit. A performance index was derived by the formula

$$\frac{\text{Actual weight loss}}{\text{Desired weight loss}} \times 100$$

This expresses the percentage of the subject's weight loss goal he actually achieved over the period of the study. A negative index indicates weight gain.

Table 1 shows the weight change and performance index for each subject in the obese study group. In this group two subjects gained weight. The other five achieved some weight reduction, with the performance indices ranging from 42 to 92.

Table 2 shows the observed weight change in the control subjects. Three of the six subjects gained weight and three lost. Four of the six changes were less than 4 pounds. One control subject gained 7 pounds and one lost 9 pounds.

Table 3 shows the changes in triceps skinfold thickness. Five of the seven subjects in the obese study group showed reduction in skinfold thickness, and all five had shown weight losses. Of the other two obese subjects, one showed increased skinfold thickness and one was unchanged. Both of

Left to right, Pauline Wright, R.N., Dr. Brown, Willard Powell, chief medical social worker, and Mrs. Erdle confer on strategies in weight-losing program.

these subjects showed weight gains. The six subjects in the control group remained unchanged.

COMMENT

This study clearly shows that weight reduction of obese handicapped patients is entirely possible. In our total push program, five of the seven obese patients lost weight. The two patients with the most ambitious goals did quite well, losing 60 percent of a 45.5 pound goal and 51 percent of a 57 pound goal, respectively. Of the two patients who gained weight, one gained 12 pounds instead of losing 4, which was her goal. She was a child with severe emotional problems and unable to accept the fact that the small desired weight loss would help her use her braces more effectively. Her weight gain may also have been an adolescent rebellion in one of the few forms available to her. The other patient who gained weight was out of our control during a long period of hospitalization.

The strong motivations of some of the patients accounted for much of the success of our program. The chief motivation was increased ambulation, such as moving from a cart to a wheelchair, or from a wheelchair to walking with braces, or walking with braces more easily. In addition there were those factors that induce nonhandicapped obese persons to want to lose weight—improved appearance, greater social acceptance, etc.

Obviously the residential school situation permits a far closer approximation to the total push approach than would be possible in a rehabilitation facility offering only day care, or individual therapy several times weekly. A great degree of supervision and the powerful effect of group morale can only be had in a residential situation. Nevertheless, we believe rehabilitative day centers can deal effectively with obesity problems even in nongroup programs.

Based on this intensive study our suggestions are that:

1. No program of weight reduction should be undertaken without the services of a competent nutritionist. Most physicians have not received detailed training in nutrition and (with few exceptions) are not qualified to provide the necessary dietary counseling. Nurses and other paramedical persons are also not professionally trained to offer sound nutritional advice.
2. The child should select his own weight reduction goal with the aid of the nutritionist and other appropriate staff members. He must be well acquainted with the reasons for weight reduction.
3. An approximation to the total push approach can be made by enlisting the aid of every staff member and fellow patient who comes in contact with the obese child. Of particular importance is the painstaking education of the child's parents. This factor is crucial and depends mainly on skillful and repeated counseling by the nutritionist.
4. An element of competition and motivation can be provided by posting in one central location the names of all children in the weight reduction program together with their weekly weights. Even though a child may be competing with others whom he may know only by name, such motivation is likely to give better results than a solo effort.
5. There should be one person in charge of the entire weight reduction program. This person should be a competent authority whom the child knows and who knows the child's problems.

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Virginia Workshop Helps Keep Environment Clean

• Clients in the Tidewater Vocational Center in Norfolk, Virginia are having an impact on keeping our environment clean. Upon demand they package and ship a product called oilsnare which is manufactured exclusively in Norfolk by Parker's Industrial Marine Service. Oilsnare is used to sop up oil from accidental spills along the country's shore line.

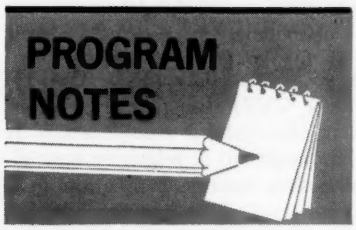
The material, which looks like long strips of plastic, absorbs 25 times its own weight. The Center's 110 workers fluff the oilsnare, weigh it, and package it for shipment. Although their production is 10 boxes per day, the work crew upped that to 50 boxes per day not long ago to meet demands of a New York Harbor spill of 38,000 gallons of fuel oil which threatened the Coney Island, Brighton, and Gravesend beaches.

Large Oregon PA, Migrant Populations Served By New Human Resource Centers

• The State of Oregon is developing three pilot community human resource centers that will attack the problem of large public assistance caseloads in three counties. The centers will operate in the model city area in Portland, in Corvallis (a middle-sized city), and in Ontario (a rural area with a large migrant population). The centers, operated by the Human Resources Department and with active participation by other divisions, such as DVR, draw part of their funds from RSA-support through expansion money.

The center concept consists of blending existing social and health services to reduce overlapping functions of the cooperating agencies and to fill in the gaps in services to needy clients. Project administrators see this as several steps beyond present operations where multiservice centers merely provide joint housing for various agencies.

Services available from State-level agencies will include vocational rehabilitation, public welfare, children's services, mental health, employment, and corrections. In addition, local governmental and private agencies will be invited to take part in center operations.



Upswing in Public Assistance Rehabilitations

• A reversal of trends in the rehabilitation of public assistance recipients occurred during fiscal year 1970 both in terms of annual rate of increase and in the proportion of these clients among all rehabilitated clients. The annual rate of increase, which had lagged behind that for all rehabilitated clients since fiscal year 1967, doubled from 8 percent in 1969 to 16 percent in 1970. This increase topped the overall increase of 11 percent by 5 percentage points. The proportion of recipients among all rehabilitated clients turned upward to 11 percent in 1970 thereby halting the downward trend observed since 1966.

This information is contained in *Trends in the Rehabilitation of Public Assistance Clients, Fiscal Years 1966 through 1970.* The report may be obtained from the Division of Monitoring and Program Analysis, RSA (Information Memorandum RSA–IM–72–30, December 17, 1971).

According to the report, the number of rehabilitated public assistance recipients rose from 20,155 to 28,308 during the 5-year period, a 40 percent increase. The leading States in terms of annual average number were Pennsylvania, California, and Florida.

These clients comprised 15 percent or more of the total rehabilitations in 18 States in 1970. This compares to only five such States in 1969. The number rehabilitated in 1970 per 10,000 recipients varied widely among the States, ranging from a high of 312 down to 34. The National rate leveled off at 98 for 1969 and 1970. The increases in the number rehabilitated annually ranged between 6 and 17 percent during the 5-year period. Nearly one-third of the States and jurisdictions showed increases in excess of 30 percent in 1970 over 1969.

Survey Studies Needs In Epilepsy Rehabilitation

• Since 1967 (all years given are fiscal years) the ratio of persons with epilepsy being rehabilitated in relation to total rehabilitations has steadily decreased from a peak of 2.2 percent of total rehabs in 1966 (3,283 epileptics rehabilitated from a total of 154,279 persons rehabilitated) to 1.6 percent in 1971 (4,600 epileptics from a total of 291,272 rehabs). Estimates for 1972 and 1973 foresee the trend continuing to the point of 1.4 percent in 1973.

This declining ratio holds true in the face of a steady increase in attention to the rehabilitation of persons with epilepsy over the years. James Jacks, Ph. D., and Jamil Toubbeh, Ph. D., joint authors of a chapter on the rehabilitation of the epileptic in a book entitled *Epilepsy Rehabilitation,* edited by Dr. George N. Wright and soon to be published have noted these trends in the rehabilitation of persons with epilepsy. They cite the progressive legislative authority that has given the program the wherewithall to include these patients in the program. They also trace research and educational thrusts into the realm

of the epileptic's social and vocational life.

The authors report on a survey of State vocational rehabilitation agencies that attempted to analyze the sudden and steady decline in the percentage of epilepsy rehabilitations. The questionnaire delved into such areas as attitudinal, legal, placement, and other barriers in the State; counselor needs; resource availability; and facility, educational, referral source needs in restoring epileptics to gainful employment.

Major findings of the survey show that (1) the barriers to the rehabilitation of persons with epilepsy are: attitudes of counselors and client coworkers, legal restrictions, limited service resources, and placement; and (2) State needs to meet increased epileptic rehabilitations are counselor training, additional service resources, development, use and support of local organizations, and public education programs aimed at attitudinal changes.

In spite of the decreasing ratio, the authors feel that a viable national epilepsy rehabilitation program will develop. In support of such anticipation they cite the recent passage of the Developmental Disabilities Act and point to the merger of various epilepsy organizations into the present Epilepsy Foundation of America which will give unified support for programs through its national stance and through its associated State chapters.

Alcoholic Rehabilitations On The Increase

• Between fiscal years 1966 and 1970 the number of alcoholics rehabilitated through RSA programs has grown sevenfold, from 1,562 cases in 1966 to 11,120 in 1970. For fiscal year 1972 RSA projects that it will rehabilitate roughly 15,000 persons who have alcoholism figuring as the major disabling condition.

Minnesota Treatment Program Serves Deaf Alcoholics

• A man is an alcoholic; he is also deaf. Thus he is plagued by an already overwhelming social disease which is now doubled by his handicap. He must depend not only on his own volition but also on the strength and assistance of others.

A group in Minnesota, the Cooperative Vocational Rehabilitation Program, (CVRP), has recognized the gravity of this complex, how ever limited, situation. The St. Peter CVRP has taken the problem into careful consideration. It has instituted a relatively new alcoholism treatment program in a local hospital; it is a program designed to help deaf alcoholics through the use of concerned interpreters and hospital officials.

The active interpreter is assigned to live in the hospital with the patients, spending a few weeks actually in their own ward. The interpreter accompanies the deaf alcoholics to Alcoholics Anonymous meetings and to various other group sessions both within and without the hospital. The interpreter's presence instills within the alcoholic a vital self-confidence as well as a feeling that someone is truly concerned about his own particular problem. Through the interpreter, two deaf patients have already found it possible to participate fully in the treatment programs organized by the hospital.

Because the hospital is perhaps the only medical center in Minnesota which has instituted such a program, the hospital administrators feel a certain responsibility toward deaf alcoholics throughout the entire State. The hospital administrators have agreed to accept patients from outside their 10-county receiving radius. Although the number of people actually benefited by this program is minimal, this fact does not deter the hospital from increasing the scope of its treatment in order to give fair and just assistance to those few people who do indeed need it.

Arizona Mounts Statewide Attack On Welfare Dependency

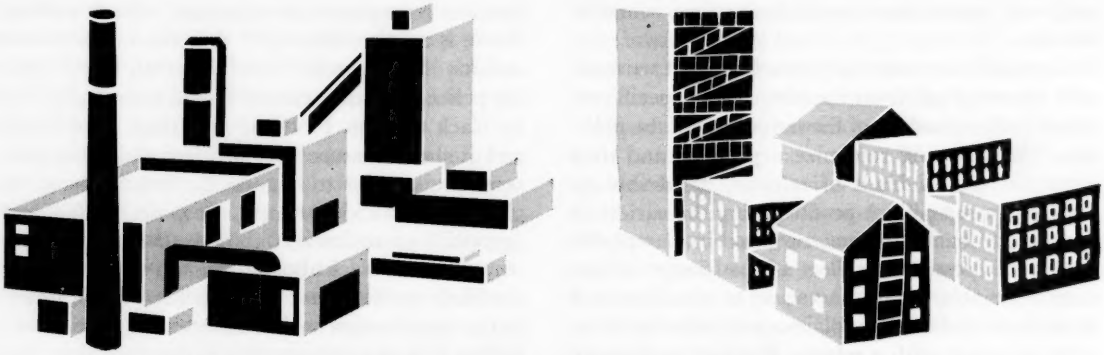
• The State of Arizona has planned a massive attack on welfare dependency through a cooperative effort of DVR, the Department of Public Welfare, the Division of Vocational Education, and the State Employment Service. The attack is being mounted on several fronts, with the State legislature's appropriation of $400,000 of State money (This is additional funds, augmenting regular appropriations for this purpose.) and with an RSA-expansion grant award of $174,874.

With these money resources, State planners hope to reduce a steadily climbing welfare clientele—5.3 percent of the State population in 1971.

The legislature's appropriation will add 23 staff members who will deal exclusively with public assistance clients. This new staff will be distributed throughout the State. They will be assigned to local district offices of vocational rehabilitation.

Expansion money will purchase the services of 35 staff in "outstationed" positions (largely in welfare offices, but also in such places as employment offices, evaluation units, and State and district offices). In addition to counselors, aides, and clerical persons, the grant will make available such specialists as a psychologist, vocational evaluators, and a facilities specialist.

This latter staff will be mainly responsible for initial case study work and for appropriate referral to local district offices of vocational rehabilitation. Within the recipient population, five target groups have been identified: 14- to 18-year-old welfare dependents, 19- to 30-year-old welfare recipients, new welfare applicants, AFDC mothers, and APTD recipients. Detailed operational service delivery plans specific for each group have been developed.



Industry: training ground for Disadvantaged

By HARRY C. TRIANDIS, Ph.D.

Several technical reports have been compiled by the investigators of an SRS-supported project at the University of Illinois at Urbana-Champaign. The project is entitled Sub-Cultural Training for the Socially-Economically Disadvantaged. It has as its goal to develop training materials for socio-culturally disadvantaged prospective employees and for the middle-class supervisors who will work with them.

This study (technical report number 3) surveyed the most significant theories of social perception and examined the most important findings concerning black and white differences. From a juxtaposition of these two sets of findings, the author derived the following suggestions for social action.

The report will be carried as a chapter in a forthcoming book entitled, *Integrating The Organization.* It is edited by Howard Fromhkin and Jack Sherwood. Free Press will publish the work.

There is a fundamental difference in the outlook of the researcher and the administrator. The researcher examines his data, finds gaps, alternative interpretations and formulates new studies. By a gradual process of elimination of alternative interpretations he arrives at a clear understanding of the nature of the relationships he is interested in. This process takes time. The administrator needs answers now; he cannot wait for the researcher to carry out 10 or 20 years of research in order to give him the answer. This conflict can be eliminated if the researcher is willing to *guess* what administrative actions might prove effective, and the administrator is willing to *test* his policies, in the manner described by Campbell.[1] The administrator's approach to social change is usually very weak, because he *assumes* that the guesses of scientists are "the truth." Let us dispel any such notions. We are willing to guess, but such educated guesses need to be tested. It is a fundamental error to assume that a reform is going to be successful. We must carry out reforms the way we

Dr. Triandis, who is author of technical report number 3, is also the project director.

carry out experiments: to guide our next round of reforms.

Campbell has correctly pointed out that we must shift our emphasis from the advocacy of specific reforms to the advocacy of the seriousness of the problem. We must first recognize a problem and then carry out *several* kinds of reforms, if possible on matched groups, if not possible using the variety of quasi-experimental designs, reviewed in Campbell's paper. It is possible to collect a broad range of data so as to be able to reject a variety of plausible rival hypotheses that might explain a particular set of results associated with a reform. We need to measure each outcome in many different ways, to ensure that our measurements have convergent validity. We must plan our reforms in such a way as to permit multiple measurement over time, so as to obtain several measures of outcomes both before and after the reform. We must guard against all kinds of methodological mistakes in the selection of the groups which we reform, which might lead to incorrect conclusions due to regression effects. If the reforms are carried out in this experimental spirit, our educated guesses may be useful. We propose several reforms here.

Managements wishing to integrate their organizations should conceive of them as providing rewards and costs. A variety of rewards are dispensed by the organization. Over and above the financial rewards, the bonuses, and the fringe benefits, there are status rewards, information rewards (such as providing special training and developing special skills), goods and services, and even affect.

In spite of the long tradition against paternalism, which is in very good standing in American society, there may be good reasons to assume a paternalistic attitude toward black employees. There is a theoretical reason to expect that this policy will be greatly appreciated by blacks: namely, they have experienced very small ingroups, and the affective attachment to a larger ingroup, such as a company, may be welcomed. For the white employee whose ingroup is larger than the company, paternalism implies restriction of freedom and is typically resented. The point is that this may not be true for the black employee. There is also evidence from studies done abroad, that paternalistic American companies succeed much more in countries in which a small ingroup is typical (e.g., Sears of Peru) than do nonpaternalistic companies.

One way to provide such a paternalistic service is to establish a "race relations" department whose function is to protect the company's black workers. There is ample evidence [2, 3] that blacks are treated unfairly by the white establishment, particularly the police. This department should trace complaints by black workers. It should give them legal advice and it should ensure that political and other pressures are exerted to change the conditions of the ghetto. Such a department, properly staffed with aggressive young lawyers, could be the most effective way to reduce black absenteeism and turnover. Once the black workers have developed a sense of loyalty to the organization which is protecting them and a feeling that the organization is ensuring that their rights as citizens are respected, they will be as loyal as the most loyal white employees.

The reduction of delinquency and deviant black behavior may require firm paternal handling and a sequence of two things: (a) a large sense of reinforcement for being a member of the particular company, and (b) instant dismissal if deviant behavior is observed. In short, deviant behavior must acquire connections with negative reinforcements of such magnitude that it cannot be seen as "paying off," under any conditions.

During black training the whole issue must be discussed openly and the employee may be told (if appropriate): "We know you have a criminal record. That is forgotten. But we have certain rules and we cannot operate this factory if we do not follow these rules. Even if you are caught stealing an item worth 1 cent, you will be instantly dismissed, the way we instantly dismiss any white employee who is caught doing something illegal."

Another useful reform would be for the management to provide for a system of interracial "courts" which will judge the misdemeanors of all employees, both black and white, and would dismiss those who steal, etc., as specified by company rules. It is important that the dismissal be instituted by the worker's black peers. It is also desirable to give each worker the experience of sitting in such a court, as the jury, at the earliest opportunity, so he can experience the system from the inside. The important thing is to eliminate the conditions under which delinquent behavior is a form of protest.

Training the Black Employee. Many of the characteristics of the black ghetto are considered undesirable by most ghetto dwellers. It is therefore ethical to change them. Many of the psychological characteristics of blacks who come to work in white-controlled industry will be reactions to the racism

of white society. It is up to management to adopt administrative policies that will counteract these traits, will modify the black stereotypes of whites, and will make the work environment moderately enjoyable for the black worker.

Ghetto blacks think of whites as superhuman exploiters, intelligent, cold, calculating manipulators, and as supremely selfish. A young black answered a sentence completion "White men are . . ." by inserting "going to do anything to keep black men down." This stereotype needs to be changed. However, most supervisors concerned with efficiency are likely to be seen confirming this stereotype. For this reason it is important to provide special training to supervisors of blacks, and special bonuses for working with black workers.

At the same time the ghetto workers must receive special training which will demonstrate to them that the company genuinely wishes to have them as employees. This training should include a variety of experiences designed to raise self-esteem, to lengthen time perspective, and to provide a feeling of "effectance." The employee should feel that his effort leads to good outcomes. It should be recognized that most of his past experience dissociated his own actions with good outcomes, and he should be told that things will be different from now on.

Black infants, less than 12 months old, may acquire a feeling of helplessness because their mothers are too busy to attend to them when they cry. Crying is extinguished and a feeling of impotence sets in. One might hope that a series of exercises in which outcomes are made to depend on his own actions, and rewards are obtained immediately, should convey to him the idea that action leads to rewards, that such sequences *exist* "in nature" and should be sought. Of course, we need experiments here to determine if providing such exercises can reverse a process which can be traced all the way back to infancy. Let us hope a reversal is possible.

A good deal of training will be required before the black employees can be introduced to the factory floor. Basic skills like using the public transportation system or an alarm clock are sometimes lacking. Most importantly, blacks often lack the motivation to stay on the job. The whole white environment is aversive to them. They associate it with oppression, anxiety, defeat, failure. Much training is required to be provided to overcome such feelings.

The training should also concentrate on rewarding punctuality. Anecdotal evidence suggests that very few trials are needed to learn to be on time, provided the motivational framework is clear. The Chicago busdrivers are fired if they report for work but 2 minutes late. Most of the drivers are black, and they are extremely prompt in arriving for work.

Blacks are highly suspicious in interpersonal relations—and with good reason. This pattern must again be broken. It requires a series of experiences in which trust responses are evoked and rewarded. In the prework training sessions trust might be evoked in prisoner dilemma–type games. If such games are structured so that cooperative and trusting responses are reinforced, it should be possible to teach such responses to the black workers.

It should also be helpful to acknowledge, when training them, that trust is indeed inappropriate in the ghetto, so that what they learn in the job setting should not necessarily be used in the ghetto. This kind of development of separate systems of behavior, one for the job and one for the ghetto, may not be any more difficult than learning two languages. Bilinguals switch from one language to another with great ease, and there is no reason to expect, on the basis of present knowledge, that this cannot also be done with other kinds of behavior patterns.

During training some elements of attribution theory,[4, 5, 6] with demonstrations, might be included to help the blacks understand the reactions of whites. According to this theory, any deviation from "normal" behavior is likely to lead to attribution of particular traits. Thus, a particular deviant behavior which the black finds highly rewarding may actually be counter-productive, in terms of his long term goals, because it creates or reinforces uncomplimentary stereotypes.

Behavior that is consistent with what others do "fades away," and is likely to "extinguish" uncomplimentary stereotypes. The best way to change uncomplimentary stereotypes is to behave in ways which are unexpected, hence will be noticed, but which are diametrically opposed to the stereotypes. Thus, a man who has the reputation of being stingy can change the stereotype by behaving generously, and so on.

In a study by Davis and Triandis,[7] naive white students negotiated with confederates of the experimenters who were well-trained blacks. The blacks were chosen to be highly articulate and were supplied with an impressive array of arguments backed up with statistics. The effect on the prejudiced whites was shattering. Never before had they seen a Negro speaking such excellent English, arguing his case with such eloquence, and backing it up with

such solid evidence. The white subjects showed a large and highly significant change in their affective responses and their attributive responses; on the other hand, their behavioral intentions changed very little. One implication from this study is that there is a need for careful selection of the blacks who are first brought into a particular department.

Selecting the Black Employee. Deductions from Jones *et al.*[8] would suggest that when blacks are introduced into a new company they must be seen as having a number of successful experiences. This condition would be dissonant to current stereotypes and would also lead to the perception of blacks as competent. An anecdote, told by an industrial consultant, supports this suggestion. In integrating a railroad, he hired blacks to train them for the *most* difficult job. Most white employees were ready to walk out, but they stayed on the job because their stereotypes were so strong that they did not believe that the blacks would be able to handle such complex jobs. When the well-chosen blacks succeeded, the opposition dissolved.

It follows that an exceptionally effective way to integrate organizations is to hire black management. Unfortunately, the limited numbers of qualified blacks for top level positions in American industry, makes this suggestion of limited practicality, but efforts must be exerted. One might, for example, seriously consider a substantial increase in scholarship aid to qualified black students planning to go to engineering school, followed by a Masters in Business Administration, since this is one of the most effective routes of entry into top management.

Black Work Assignments. Great care must be taken with the matching of the black's ability and training with the difficulty of the job. Since blacks have low self-esteem, it is essential to structure the situation so that they will rarely fail and will experience success very frequently. At the same time, the jobs should not be too easy, since such jobs are low in prestige and often boring. Optimal matching requires jobs of intermediate complexity. Of course, training, overlearning, the availability of counseling help, and the activities of the race-relations department will also be important in keeping the worker from becoming discouraged and in ensuring that he does not quit.

Training the White Employees. A successful program requires the training of the white workers as well. They must see the essential similarities of blacks and whites and their common humanity. They must realize something about the unity of mankind, the way racial and cultural differences develop, the role of their ancestors in creating a culture which leads to several forms of discrimination, the need for integration and the reduction of conflict. Some of the basic defense mechanisms which they employ and which feed their prejudice must be made clear to them. The reduction of the instrumental relevance of the black cue must be accomplished in such training. The white workers must learn that a "successful black" is not a status incongruent stimulus. Training exercises in which rewards follow friendly, constructive behaviors in interracial settings, should be useful.

Structuring the Environment. Administrative action can also be directed toward structuring the jobs, so that blacks and whites will have superordinate goals, will experience a good deal of equal status contact under rewarding conditions, and special bonuses will be dispensed when interracial groups cooperate and develop interdependence.

Many of these suggestions are dramatic, such as the casting of the company as the protector of the rights of the black employee, but only dramatic shifts in present policy are likely to lead to significant improvements in interracial relations and to the integration of the organization.

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EPILEPSY the non-medical aspects

Orville Karan

. . . the mass media have been instrumental in shaping some of the positive attitudes towards epilepsy . . .

Most epileptic episodes last anywhere from a few seconds to several minutes; but aside from these brief periods, the individual is not incapacitated by his disability. Yet the epileptic is denied many of the privileges which others accept as commonplace. The privileges of education, social contact, vocational opportunities, and even marriage are often denied to one with epilepsy because he is thought to be dangerous to himself or those around him, or too handicapped to be allowed equal rights and opportunities. Other beliefs are that very little can be done to reduce or eliminate these seizures. Employers do not want to hire epileptics because they fear an increase in their insurance premiums.

Unfortunately, these beliefs have become so strongly rooted in the minds of most people that they experience a psychological expectation or set toward the epileptic. He has not been viewed as an individual with a disability but rather as a member of a stereotyped group having medical, vocational, social, psychological, and educational limitations.

Approximately 1.5 to 2 million people in this country are epileptics. Somewhere between 12–21 percent of epileptics are unemployed, as many as 420,000 possible employees not working.[1] This fact is especially tragic when the literature on epilepsy reports very optimistically that 75–85 percent of persons with epilepsy can have their seizures controlled sufficiently to live a normal life.[2]

Although it is true that with proper medical diagnosis and prescription most of today's epileptics could become seizure free, this is only one part of the total handicap of this disability. The other parts are the educational, vocational, social, and psychological limitations which are imposed on those with epilepsy.

Attitudes Toward Epilepsy

The results of recent studies indicate that positive and well meaning attitudes toward the epileptic are on the increase. More people are aware of the nature of epilepsy than ever before. Undoubtedly the mass media have been instrumental in shaping some of these positive attitudes towards epilepsy as well as towards other disability groups. Still lacking, however, is an understanding of the importance of the roles of social, vocational, educational, and psychological variables. Epilepsy is still considered mainly a medical problem, and although positive steps have been taken to consider this aspect of the disability not enough is being done for the other aspects.

In the years 1949, 1954, 1959, and 1964, Dr. George Gallup of the American Institute of Public Opinion, obtained answers to questions about epilepsy from representative members of the adult population throughout the U.S. During this 15-year

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period, 92.9 percent of the people interviewed had some knowledge of epilepsy. When those familiar with epilepsy were asked if they would object to their children playing with epileptics, 57 percent answered "no" in 1949, 68 percent in 1957, 67 percent in 1959, and 77 percent in 1964. When asked if they thought epilepsy was a form of insanity, 59 percent said "no" in 1949, 68 percent in 1954, 74 percent in 1959, and 79 percent in 1964. When asked if epileptics should be employed, 45 percent said "yes" in 1949, 60 percent in 1954, 75 percent in 1959, and 82 percent in 1964.

In each of the four surveys, the most favorable opinion was among the better educated, better employed, younger, and urban members of the population. Eastern, midwestern, and western States showed less prejudice than those in the south.

Milan [3] investigated the attitudes toward epilepsy in higher education. The findings indicated that the attitude of college administrators toward epilepsy can be considered to be favorable to highly favorable. The mean attitude score was found to be influenced by size of enrollment and the level of degree granted. It was not found to be influenced by geographic region, institutional control, academic practices, type of student body, or religious affiliation of the institution.

Vocational Adjustment

A major obstacle facing the epileptic is the biased attitude of employers. Some epileptics and even professional workers in the field believe that it is best not to tell the prospective employer about the condition. To explore this situation, Forrest [4] conducted a followup study on a group of controlled epileptics. About one half of the group told prospective employers of their condition and the other half did not. Those who hid their condition were able to secure jobs more easily, but they had more seizures on the job and were more often fired because of their seizures. In the group that told, there was much greater difficulty in obtaining employment; but once placed, they had fewer seizures and seldom lost their jobs after a seizure. All the subjects believed that the increased anxiety over a possible seizure felt by the group that did not tell was directly related to their higher rate of seizures. Forrest concluded that although there was more initial anxiety in the group members that told of their epilepsy, there was better job and personal adjustment in this group than in the other group.

Dennerll, Bodin, Gonzales, Schwarts and Lin [5] found that identifying the epileptic to his employer was not sufficient to account for obtaining and keeping employment. In their study, the authors found that the general personality trait of social competence is an important factor in successful employment of persons with epilepsy.

This may explain, at least partially, the relatively low percentage of successful rehabilitants of those persons referred for vocational help because of an inability to obtain and keep regular employment. These clients may be lacking in the trait of social competency, or display socially disabling predispositions, or have poor personal hygiene so that they would be in the lower half of the employability continuum or in the poor prognosis range. These may be the permanent, significantly unemployed group among epileptics.

Job Problems and Performance

On the basis of observations made in his study, Udel [6] suggested: (a) any applicant with epilepsy must be appraised individually as to his capacity for employment and the degree of his impairment for proper placement or rejection; (b) the industrial physician should take a more active role in supervising the epileptic employee through achievement and maintenance of seizure control.

Schwade [7] agreed that the industrial physician may play an instrumental role in helping the epileptic. He believed the problem of securing employment is not due to the opinion of the company president, but rather to the opinion of the foreman or safety supervisor who does not usually want an epileptic. The man who works right next to the epileptic is the one who objects most of all. In fact, an employer himself may approve of hiring an epileptic but be blocked by his personnel. It is here that the industrial physician may be helpful, because he can serve as an interpreter. He can explain to both management and personnel staffs the extent of the physical handicap of epilepsy and under what conditions the epileptic can be safely employed.

A study was carried out by two oil refineries [8] with a combined working force of 9,600 employees to determine the incidence, sickness rate, accident experience, and frequency rate of its epileptic em-

ployees. The medical records of all employees were studied, and the data indicated that 58 employees or roughly 6 percent were epileptic. Of this sample, 57 percent were of the idiopathic variety, and 43 percent were of the symptomatic variety. The ratio of 6:1,000 compares favorably to the incidence of epilepsy within the general population which is considered to be approximately 5:1,000.[8]

The results of this study are as follows: (a) 69 percent of the sample had fewer than five known attacks and only 12 percent had more than 10 attacks; (b) 81 percent of the sample had average or lower than average sickness absenteeism and only 19 percent had excessive absenteeism; (c) accident experience indicated that 2.3 days per million manhours were lost due to accidents on the job. The results of this study indicate that the employed epileptic has few attacks on the job, has better than average attendance and has very few injuries on the job compared to his nonepileptic coworker.

The records of 51 known epileptic workers were examined to determine the incidence of epilepsy in an industrial population, to evaluate the influence of epilepsy on work performance, and to delineate factors which could be changed to promote employment of this disability group (Ladd,[9]). Of the epileptics studied, 72 percent had job performance ratings equal to or better than those of their coworkers, and they had lower accident rates. The majority of epileptics included in this study were demonstrated to have normal work performance. The important aspects of each case being evaluated for employment were considered to be the degree of seizure, type of neurological defect, and careful placement. It was also suggested that efforts made to return epileptics either to their former job or to similar work may have more beneficial effects than job training.

Workmen's Compensation

Figures indicate that up to 21 percent of the epileptics are currently unemployed,[10] yet are potentially capable of becoming taxpayers if given the chance. A substantial objection of employers to hiring the handicapped, including epileptics, is that the handicapped would require an increase in workmen's compensation costs.

This reason is only an excuse. According to the Epilepsy Foundation of America, an employer does not have to pay a higher premium if he employs persons with epilepsy, whether these persons have a higher accident rate or not. When calculating the premiums for workmen's compensation coverage, insurance companies never consider whether or not an employer has epileptic employees. This generalization applies for both class and individual risk rates. It is likely that a number of employers know their fears are unfounded, but they find it to be a more convenient explanation than disclosing the real reasons for not hiring such persons.

Indeed, epileptics appear to be better than average employees. Studies have shown that the controlled epileptic is more careful than the average worker, has fewer accidents on the job, and is absent from work less frequently. Barrow and Fabing [11] felt that the accident experience of epileptics placed in jobs appropriate to their handicap is as good as that of normal persons. When given reasonable job placement consideration, epileptic workers as a group are fully able to compete successfully with unimpaired workers similarly placed.

The second injury funds of only two States, Kansas and Ohio, specifically cover employees with epilepsy. However, the language of the laws of 18 other States may be sufficiently broadened to include such employees. Although there is no evidence that persons with epilepsy have a higher than average incidence of occupational injuries, the existence of a second injury fund that covers epilepsy would be helpful in dispelling the notion that the hiring of such persons increases an employer's workmen's compensation premium.

Counseling With Epileptics

A higher percentage of epileptics than of other disability groups is categorized by vocational rehabilitation personnel as too severely disabled to be accepted as clients.[12] Epileptics are also rejected by DVR on grounds of having no vocational handicap.

Eligibility determination is a decision made by the rehabilitation counselor on the basis of the medical, psychological, social, vocational, and educational information about his client. When a counselor rejects the epileptic client on the grounds that the disability is not handicapping to employment it may be because he is not fully aware of the conditions which are not only secondary but may even be more handicapping than the seizures themselves. Such things as attitudes of employers, insufficient environmental stimulation, outdated laws, and a

poor self-concept may be more handicapping to the epileptic than an occasional seizure. But, without taking these into consideration, the counselor may honestly believe that there is no reason why his client cannot work. Other reasons for rejection may be that he does not have the time, does not want to get involved, and/or believes that the epileptic is the most difficult client to place into employment.

Requirements of the Counselor

The counselor must know the facts about epilepsy, what medication his client is taking, how to deal with a seizure, and about the agencies, organizations, and services which are available to help the epileptic.

In counseling with the epileptic, the counselor must accept him as a person rather than as a disability or a case. He must reassure his client that he can achieve, despite the client's limitations and the limitations society imposes on him. It is important to prepare the client to deal with the rejection he is likely to experience even after he has established himself, and to help him form a proper self-image. The counselor must understand the need for medication to control seizures. It is important that the counselor learn the client's goals and that he helps him to find a career that will provide personal satisfaction, development, and growth rather than simply "safety." It is the counselor's responsibility to evaluate and understand the epileptic client as a whole person, including his defenses, his view of his disability, and the social and familiar milieu in which he lives.

On the basis of 22 years of experience as a rehabilitation counselor, Creaser [13] summarized his feelings about working with epileptic clients. He feels that the counselor must be enthusiastic about helping the epileptic if he intends to be helpful. He said that all epileptics are different, but as a group, he found them astonishing, unbelieveably courageous, fascinating and inspiring.[13] Rehabilitation counselors who lack enthusiasm will have a difficult time, for the epileptics show honor to the counselor by coming out of their dungeons seeking his help.

Indications are that it is not necessary for a counselor to utilize any specialized counseling theories to be effective with his epileptic client. Rather, there is a consensus among researchers that it is more important for the counselor to be enthusiastic, realistic, and honest with his client.

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A Program With Heart

Coralito is a small, laughing cherub whose white smock is decorated by a large red heart. He is not, however, to be found pictured on the front of a typical Valentine's Day card; rather, he is seen beaming down from posters, billboards, buttons, sweatshirts, and even from official medical forms. This endearing angel is the unlikely advertising symbol of a widespread pediatric cardiovascular program established in Puerto Rico. The program is funded by HEW's Health Services and Mental Health Administration.

A symbol of good life, good health, and happiness, Coralito's presence is designed to involve the people of the island in a concerned fight against cardiovascular diseases in children. His frequent appearance in cities and villages, in buses and trains, in homes and institutions will hopefully make parents, teachers, and children more aware of the fact that heart defects (both congenital and acquired) are not always fatal.

The program, symbolized by little Coralito, brings to the children of Puerto Rico a complex of vital activities aimed at reducing the high rate of heart disease and related deaths. The services provided include: detection, cure, prevention, education, and rehabilitation. A brightly-colored, mobile van is used at schools to screen children for heart defects.

REHABILITATION RECORD

The weakest ink is better than the strongest memory

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